THE GENERAL STATUTES OF NORTH CAROLINA

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ANNOTATED

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1997 CUMULATIVE SUPPLEMENT

VOLUME 10

THE GENERAL STATUTES OF NORTH CAROLINA

ANNOTATED

1997 CUMULATIVE SUPPLEMENT

Volume 10

Chapters 58 and 58A

Prepared under the supervision of

The Department of Justice
of the State of North Carolina

BY

The Editorial Staff of the Publishers

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Annotated through 486 S.E.2d 626. For complete scope of annotations, see scope of volume page.

Place Behind Supplement Tab in Binder Volume. This Supersedes Previous Supplement, Which May Be Retained for Reference Purposes.

MICHIE
Law Publishers
Charlottesville, Virginia
1997

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Preface

This Cumulative Supplement to Volume 10 contains the general laws of a permanent nature enacted by the General Assembly through the 1997 Regular Session, which are within the scope of such volume, and brings to date the annotations included therein.

Amendments are inserted under the same section numbers appearing in the General Statutes, and new laws appear under the proper chapter headings.

Chapter analyses show all affected sections, except sections for which catchlines are carried for the purposes of notes only. An index to all statutes codified herein will appear in the Replacement Index Volumes.

A majority of the Session Laws are made effective upon ratification, but a few provide for stated effective dates. If the Session Law makes no provision for an effective date, the law becomes effective under G.S. 120-20 “from and after 30 days after the adjournment of the session” in which passed.

Beginning with the opinions issued by the North Carolina Attorney General on July 1, 1969, any opinion which construes a specific statute is cited as an annotation to that statute. For a copy of an opinion or of its headnotes write the Attorney General, P.O. Box 629, Raleigh, N.C. 27602.

The members of the North Carolina Bar are requested to communicate any defects they may find in the General Statutes or in this Cumulative Supplement and any suggestions they may have for improving the General Statutes, to the Department of Justice of the State of North Carolina, or to Michie, Law Publishers, Charlottesville, Virginia.

User's Guide

In order to assist both the legal profession and the layperson in obtaining the maximum benefit from the North Carolina General Statutes, a User's Guide has been included in Volume 1. This guide contains comments and information on the many features found within the General Statutes intended to increase the usefulness of this set of laws to the user. See the main volume for the complete User's Guide.

Scope of Volume

Statutes:

Permanent portions of the General Laws enacted by the General Assembly through the 1997 Regular Session affecting Chapters 58 and 58A of the General Statutes.

Annotations:

Sources of the annotations to the General Statutes appearing in this volume are:

North Carolina Reports through Volume 344, p. 732.
North Carolina Court of Appeals Reports through Volume 123, p. 790.
South Eastern Reporter 2nd Series through Volume 486, p. 626.
Federal Reporter 3rd Series through Volume 116, p. 875.
Federal Supplement through Volume 965, p. 1486.
Federal Rules Decisions through Volume 172, p. 600.
Bankruptcy Reports through Volume 209, p. 549.
Supreme Court Reporter through Volume 117, p. 1864.
North Carolina Law Review through Volume 75, p. 1088.
Wake Forest Law Review through Volume 32, p. 217.
Campbell Law Review through Volume 18, p. 201.
Duke Law Journal through Volume 45, p. 1088.
North Carolina Central Law Journal through Volume 25, p. 100.
Opinions of the Attorney General.

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ARTICLE 1.

Title and Definitions.

§ 58-1-5. Definitions.

In this Chapter, unless the context clearly requires otherwise:

(1) "Alien company" means a company incorporated or organized under the laws of any jurisdiction outside of the United States.

(2) "Commissioner" means Commissioner of Insurance of North Carolina or an authorized designee of the Commissioner.

(3) "Company" or "insurance company" or "insurer" includes any corporation, association, partnership, society, order, individual or aggregation of individuals engaging or proposing or attempting to engage as principals in any kind of insurance business, including the exchanging of reciprocal or interinsurance contracts between individuals, partnerships and corporations.

(4) "Department" means Department of Insurance of North Carolina.

(5) "Domestic company" means a company incorporated or organized under the laws of this State.

(6) "Foreign company" means a company incorporated or organized under the laws of the United States or of any jurisdiction within the United States other than this State.

(7) "NAIC" means the National Association of Insurance Commissioners.

(8) "Nuclear insured" means a public utility procuring insurance against radioactive contamination and other risks of direct physical loss at a nuclear electric generating plant.

(9) "Person" means an individual, partnership, firm, association, corporation, joint-stock company, trust, any similar entity, or any combination of the foregoing acting in concert. "Person" does not mean the State of North Carolina or any county, city, or other political subdivision of the State of North Carolina.

(10) The singular form shall include the plural, and the masculine form shall include the feminine wherever appropriate. (1899, c. 54, s. 1; Rev., s. 4678; C.S., s. 6261; 1945, c. 383; 1971, c. 510, s. 1; 1987, c. 864, s. 34; 1995, c. 193, s. 1.)

Editor's Note. — Session Laws 1995, c. 193, s. 67 contains a severability clause.

CASE NOTES

Quoted in N.C. Steel, Inc. v. National Council on Comp. Ins., 123 N.C. App. 163, 472 S.E.2d 578 (1996).

§ 58-1-15. Warranties by manufacturers, distributors, or sellers of goods or services.

(a) As used in this section:

(1) "Goods" means all things that are moveable at the time of sale or at the time the buyer takes possession. "Goods" includes things not in existence at the time the transaction is entered into; and includes things that are furnished or used at the time of sale or subsequently in modernization, rehabilitation, repair, alteration, improvement, or construction on real property so as to become a part of real property whether or not they are severable from real property.

(2) "Services" means work, labor, and other personal services.

(b) Any warranty made solely by a manufacturer, distributor, or seller of goods or services without charge, or an extended warranty offered as an option and made solely by a manufacturer, distributor, or seller of goods or services for charge, that guarantees indemnity for defective parts, mechanical or electrical breakdown, labor, or any other remedial measure, including replacement of goods or repetition of services, shall not be a contract of insurance under Articles 1 through 64 of this Chapter; however, service agreements on motor vehicles are governed by G.S. 58-1-25, 58-1-35, and 58-1-36. Service agreements on home appliances are governed by G.S. 58-1-30, 58-1-35, and 58-1-36.

(c) Nothing in this section affects the provisions of Article 28 of this Chapter. Any warranty or extended warranty made by any person other than the manufacturer, distributor, or seller of the warranted goods or services is a contract of insurance.

(d) Repealed by Session Laws 1989 (Regular Session, 1990), c. 1021, s. 3, effective July 27, 1990. (1959, c. 866; 1975, cc. 643, 788; 1977, c. 185; 1987, c. 369; 1989, c. 789, s. 2; 1989 (Reg. Sess., 1990), c. 1021, s. 3; 1991 (Reg. Sess., 1992), c. 1014, s. 2; 1995, c. 193, s. 2.)

Editor's Note. — Session Laws 1995, c. 193, s. 67 contains a severability clause.

§ 58-1-25. Motor vehicle service agreement companies.

(a) This section applies to all motor vehicle service agreement companies soliciting business in this State, but it does not apply to performance guarantees, warranties, or motor vehicle service agreements made by

(1) A manufacturer,
(2) A distributor, or
(3) A subsidiary or affiliate of a manufacturer or a distributor, where fifty-one percent (51%) or more of the subsidiary or affiliate is owned directly or indirectly by
    a. The manufacturer,
    b. The distributor, or
    c. The common owner of fifty-one percent (51%) or more of the manufacturer or distributor

in connection with the sale of motor vehicles. This section does not apply to any motor vehicle dealer licensed to do business in this State (i) whose primary business is the retail sale and service of motor vehicles; (ii) who makes and administers its own service agreements with or without association with a third-party administrator or who makes its own service agreements in association with a manufacturer, distributor, or their subsidiaries or affiliates; and (iii) whose service agreements cover only vehicles sold by the dealer to its retail customer; provided that the dealer complies with G.S. 58-1-35 and G.S. 58-1-36. A motor vehicle dealer who sells a motor vehicle service agreement to a consumer, as defined in 15 U.S.C. § 2301(3), is not deemed to have made a written warranty to the consumer with respect to the motor vehicle sold or to have entered into a service contract with the consumer that applies to the motor vehicle, as provided in 15 U.S.C. § 2308(a), if: (i) the motor vehicle dealer acts as a mere agent of a third party in selling the motor vehicle service agreement; and (ii) the motor vehicle dealer would, after the sale of the motor vehicle service agreement, have no further obligation under the motor vehicle service agreement to the consumer to service or repair the vehicle sold to the consumer at or within 90 days before the dealer sold the motor vehicle service agreement to the consumer.

(b) The following definitions apply in this section and in G.S. 58-1-30, 58-1-35, and 58-1-36:

(1) Authorized insurer. — An insurance company authorized to write liability insurance under Articles 7, 16, 21, or 22 of this Chapter.

(2) Distributor. — Defined in G.S. 20-286(3).

(3) Licensed insurer. — An insurance company licensed to write liability insurance under Article 7 or 16 of this Chapter.

(4) Motor vehicle. — Defined in G.S. 20-4.01(23), but also including mopeds as defined in G.S. 20-4.01(27)d1.

(5) Motor vehicle service agreement. — Any contract or agreement indemnifying the motor vehicle service agreement holder against loss caused by failure, arising out of the ownership, operation, or use of a motor vehicle, of a mechanical or other component part of the motor vehicle that is listed in the agreement. The term does not mean a contract or agreement guaranteeing the performance of parts or lubricants manufactured by the guarantor and sold for use in connection with a motor vehicle where no additional consideration is paid or given to the guarantor for the contract or agreement beyond the price of the parts or lubricants.

(6) Motor vehicle service agreement company. — Any person that issues motor vehicle service agreements and that is not a licensed insurer.

(c) through (g) Repealed by Session Laws 1993 (Reg. Sess., 1994), c. 730, s. 3. (1991 (Reg. Sess., 1992), c. 1014, s. 1; 1993, c. 504, ss. 47, 48; c. 539, s. 442; 1994, Ex. Sess., c. 24, s. 14(c); 1993 (Reg. Sess., 1994), c. 730, ss. 3, 4; 1995, c. 193, s. 3.)

Editor's Note. — Session Laws 1995, c. 193, s. 67 contains a severability clause.

Effect of Amendments. — The 1995 amendment, effective June 7, 1995, in subsection (a), in the second sentence added "and G.S. 58-1-36" to the end of the sentence, substituted "is not" for "shall not be" preceding "deemed to have" in the third sentence; and substituted "G.S. 58-1-30, 58-1-35, and 58-1-36" for "G.S. 58-1-30 through G.S. 58-1-50" in the introductory language of subsection (b).

§ 58-1-35. Miscellaneous requirements for motor vehicle and home appliance service agreement companies.

(a) The provisions of this section and G.S. 58-1-36 apply to companies specified in G.S. 58-1-25 and G.S. 58-1-30.

(b) The following definitions apply in this section and in G.S. 58-1-36:

(1) Service agreement. — Includes motor vehicle service agreements and home appliance service agreements.

(2) Service agreement company. — Includes motor vehicle service agreement companies and home appliance service agreement companies.

(c) Before the sale of any service agreement, the service agreement company shall give written notice to the customer clearly disclosing that the purchase of the agreement is not required either to purchase or to obtain financing for a motor vehicle or home appliance, as the case may be.

(d) No service agreement may be used in this State by any service agreement company if the agreement:

(1) In any respect violates, or does not comply with, the laws of this State;

(2) Contains, or incorporates by reference when incorporation is otherwise permissible, any inconsistent, ambiguous, or misleading clauses or any exceptions and conditions that deceptively affect the risk purported to be assumed in the general coverage of the agreement;

(3) Has any title, heading, or other indication of its provisions that is misleading; or

(4) Is printed or otherwise reproduced in a manner that renders any material provision of the agreement substantially illegible.

(e) All service agreements used in this State by a service agreement company shall:

(1) Not contain provisions that allow the company to cancel the agreement in its discretion other than for nonpayment of premiums or for a direct violation of the agreement by the consumer where the service agreement states that violation of the agreement would subject the agreement to cancellation;

(2) With respect to a motor vehicle service agreement as defined in G.S. 58-1-25(b)(1), provide for a right of assignability by the consumer to a subsequent purchaser before expiration of coverage if the subsequent purchaser meets the same criteria for motor vehicle service agreement acceptability as the original purchaser; and

(3) Contain a cancellation provision allowing the consumer to cancel at any time after purchase and receive a pro rata refund less any claims paid on the agreement and a reasonable administrative fee, not to exceed ten percent (10%) of the amount of the pro rata refund.

(f) Each service agreement company, as a minimum requirement for permanent office records, shall maintain:

(1) A complete set of accounting records, including a general ledger, cash receipts and disbursements journals, accounts receivable registers, and accounts payable registers.

(2) Memorandum journals showing the service agreement forms issued to the company salespersons and recording the delivery of the forms to dealers.

(3) Memorandum journals showing the service agreement forms received by dealers and indicating the disposition of the forms by the dealers.

(4) A detailed service agreement register, in numerical order by agreement number, of agreements in force. The register shall include the following: agreement number, date of issue, issuing dealer, name of agreement holder, description

of item covered, service agreement period (and, if applicable, mileage), gross premium, total commission paid, and net premium.

(5) A detailed claims register, in numerical order by service agreement number. The register shall include the following information: agreement number, date of issue, date claim paid, and, if applicable, disposition other than payment and reason for the disposition.

(g) Repealed by Session Laws 1993 (Reg. Sess., 1994), c. 730, s. 3, effective July 11, 1994.

(h) No insurer or service agreement company shall act as a fronting company for any unauthorized insurer or service agreement company that is not in compliance with this section. As used in this subsection, "fronting company" means a licensed insurer or service agreement company that, by reinsurance or otherwise, generally transfers to one or more unauthorized insurers or service agreement companies that are not in compliance with this section a substantial portion of the risk of loss under agreements it writes in this State.

(i) All funds belonging to insurers, companies, or others received by a salesperson of a service agreement are trust funds received by the salesperson in a fiduciary capacity; and the salesperson, in the applicable regular course of business, shall account for and pay the funds to the person entitled to the funds. Any salesperson who, not being entitled to the funds, diverts or appropriates the funds or any portion of the funds, other than funds representing the salesperson's commission if authorized by the salesperson agreement, to his or her own use, upon conviction is guilty of embezzlement under G.S. 14-90.

(j) Any person who knowingly offers for sale or sells a service agreement for a company that has failed to comply with the provisions of this section is guilty of a Class 1 misdemeanor. All service agreement companies and individuals selling service agreements are subject to G.S. 75-1 through G.S. 75-19.

(k) Repealed by Session Laws 1993 (Reg. Sess., 1994), c. 730, s. 2, effective October 1, 1994.

(*l*) No service agreement company shall use in its name, contracts, literature, advertising in any medium, or any other printed matter the words "insurance", "casualty", "surety", "mutual", or any other words descriptive of the insurance business or deceptively similar to the name or description of any insurer doing business in this State, except to indicate that the obligations of the contract are insured by an insurance company. (1991 (Reg. Sess., 1992), c. 1014, s. 1; 1993, c. 504, ss. 50, 51; c. 539, s. 444; 1994, Ex. Sess., c. 24, s. 14(c); 1993 (Reg. Sess., 1994), c. 730, ss. 2, 3, 5; 1995, c. 193, ss. 4, 5.)

Editor's Note. — Session Laws 1995, c. 193, s. 67 contains a severability clause.

ARTICLE 2.

Commissioner of Insurance.

§ 58-2-1. Department established.

CASE NOTES

Cited in N.C. Steel, Inc. v. National Council on Comp. Ins., 123 N.C. App. 163, 472 S.E.2d 578 (1996).

§ 58-2-40. Powers and duties of Commissioner.

The Commissioner shall:

(1) See that all laws of this State that the Commissioner is responsible for administering and the provisions of this Chapter are faithfully executed; and to that end the Commissioner is authorized to adopt rules in accordance with Chapter 150B of the General Statutes, in order to enforce, carry out and make effective the provisions of those laws. The Commissioner is also authorized to adopt such further rules not contrary to those laws that will prevent persons subject to the Commissioner's regulatory authority from engaging in practices injurious to the public.

(2) Have the power and authority to adopt rules pertaining to and governing the solicitation of proxies, including financial reporting in connection therewith, with respect to the capital stock or other equity securities of any domestic stock insurance company.

(3) Prescribe to the companies, associations, orders, or bureaus required by Articles 1 through 64 of this Chapter to report to the Commissioner, the necessary forms for the statements required. The Commissioner may change those forms from time to time when necessary to secure full information as to the standing, condition, and such other information desired of companies, associations, orders, or bureaus under the jurisdiction of the Department.

(4) Receive and thoroughly examine each financial statement required by Articles 1 through 64 of this Chapter.

(5) Report in detail to the Attorney General any violations of the laws relative to insurance companies, associations, orders and bureaus or the business of insurance; and the Commissioner may institute civil actions or criminal prosecutions either by the Attorney General or another attorney whom the Attorney General may select, for any violation of the provisions of Articles 1 through 64 of this Chapter.

(6) Upon a proper application by any citizen of this State, give a statement or synopsis of the provisions of any insurance contract offered or issued to the citizen.

(7) Administer, or the Commissioner's deputy may administer, all oaths required in the discharge of the Commissioner's official duty.

(8) Compile and make available to the public such lists of rates charged, including deviations, and such explanations of

coverages that are provided by insurers for and in connection with contracts or policies of (i) insurance against loss to residential real property with not more than four housing units located in this State and any contents thereof or valuable interest therein and other insurance coverages written in connection with the sale of such property insurance and (ii) private passenger (nonfleet) motor vehicle liability, physical damage, theft, medical payments, uninsured motorists, and other insurance coverages written in connection with the sale of such insurance, as may be advisable to inform the public of insurance premium differentials and of the nature and types of coverages provided. The explanations of coverages provided for in this section must comply with the provisions of Article 38 of this Chapter.

(9) Adopt rules governing what shall constitute an uninsurable facility for the purposes of G.S. 143-215.104E(b). The rules shall base the determination of uninsurability on the availability of pollution and remediation legal liability insurance at an annual premium amount that is affordable and proportionate to premium amounts charged for coverage of facilities at which dry-cleaning solvent contamination is not known to be present. In no event shall the annual premium amount on which a determination of uninsurability is based be greater than three times the average premium that is charged for coverage of facilities at which dry-cleaning solvent contamination is not known to be present. (1899, c. 54, s. 8; 1905, c. 430, s. 3; Rev., s. 4689; C.S., s. 6269; 1945, c. 383; 1947, c. 721; 1965, c. 127, s. 1; 1971, c. 757, s. 1; 1977, c. 376, s. 1; 1979, c. 755, s. 19; c. 881, s. 1; 1981, c. 846, s. 2; 1989, c. 485, s. 29; 1991, c. 644, s. 26; 1997-392, s. 3.)

Editor's Note. — Session Laws 1997-392, s. 5, provides: "This act constitutes a recent act of the General Assembly within the meaning of G.S. 150B-21.1. The Environmental Management Commission may adopt temporary rules to implement this act until 1 January 1999."

Effect of Amendments. — The 1997 amendment, effective October 1, 1997, added subdivision (9).

CASE NOTES

Cited in North Carolina Life & Accident & Health Ins. Guar. Ass'n v. Alcatel, 876 F. Supp. 748 (E.D.N.C. 1995).

§ 58-2-50. Examinations and investigations.

All examinations and investigations provided for by this Chapter may be conducted by the Commissioner personally or by one or more deputies, investigators, actuaries, examiners or employees designated for the purpose. If the Commissioner or any investigator appointed to conduct the investigations is of the opinion that there is evidence to charge any person or persons with a criminal violation of any provision of this Chapter, the Commissioner may arrest with warrant or cause the person or persons to be arrested. (1945, c. 383; 1969, c. 1009; 1995, c. 193, s. 6.)

Editor's Note. — Session Laws 1995, c. 193, s. 67 contains a severability clause.

§ 58-2-52. Appeals and rate-making hearings before the Commissioner.

(a) The Commissioner may adopt rules for the hearing of appeals by the Commissioner or the Commissioner's designated hearing officer under G.S. 58-36-35, 58-37-65, 58-45-50, 58-46-30, 58-48-40(c)(7), 58-48-42, and 58-62-51(c). These rules may provide for prefiled evidence and testimony of the parties, prehearing statements and conferences, settlement conferences, discovery, subpoenas, sanctions, motions, intervention, consolidation of cases, continuances, rights and responsibilities of parties, witnesses, and evidence.

(b) Notwithstanding G.S. 150B-38(h), hearing procedures for rate filings made by the North Carolina Rate Bureau shall be governed by the provisions of Article 36 of this Chapter and G.S. 150B-39 through G.S. 150B-41. The Commissioner may adopt rules for those hearings.

(c) Appeals under the statutes cited in subsection (a) of this section are not contested cases within the meaning of G.S. 150B-2(2). (1993, c. 409, s. 23; 1995, c. 193, s. 7.)

Editor's Note. — Session Laws 1995, c. 193, s. 67 contains a severability clause.

§ 58-2-70. Civil penalties or restitution for violations; summary suspension of license or certificate.

CASE NOTES

Stated in N.C. Steel, Inc. v. National Council on Comp. Ins., 123 N.C. App. 163, 472 S.E.2d 578 (1996).

§ 58-2-75. Court review of orders and decisions.

CASE NOTES

Quoted in North Carolina Life & Accident & Health Ins. Guar. Ass'n v. Alcatel, 876 F. Supp. 748 (E.D.N.C. 1995).

Stated in N.C. Steel, Inc. v. National Council on Comp. Ins., 123 N.C. App. 163, 472 S.E.2d 578 (1996).

Cited in St. Paul Fire & Marine Ins. Co. v. North Carolina Motor Vehicle Reinsurance Facility, 124 N.C. App. 450, 476 S.E.2d 897 (1996).

§ 58-2-80. Court review of rates and classification.

CASE NOTES

Calculation of Profit Provisions. — There was substantial and material evidence to support the Commissioner's use of the more conservative statutory accounting principles (SAP) in calculating the profit provisions. State ex rel. Comm'r of Ins. v. North Carolina Rate Bureau, 124 N.C. App. 674, 478 S.E.2d 794 (1996).

Premium-to-Surplus Ratio. — There was substantial evidence to support the Commissioner's selection of the traditional standard 2 to 1 for the premium-to-surplus ratio. State ex rel. Comm'r of Ins. v. North Carolina Rate Bureau, 124 N.C. App. 674, 478 S.E.2d 794 (1996).

§ 58-2-90. Extent of review under § 58-2-80.

CASE NOTES

Cited in State ex rel. Comm'r of Ins. v. North Carolina Rate Bureau, 124 N.C. App. 674, 478 S.E.2d 794 (1996).

§ 58-2-131. Examinations to be made; authority, scope, scheduling, and conduct of examinations.

(a) This section and G.S. 58-2-132 and G.S. 58-2-133 shall be known and may be cited as the Examination Law. The purpose of the Examination Law is to provide an effective and efficient system for examining the activities, operations, financial condition, and affairs of all persons transacting the business of insurance in this State and all persons otherwise subject to the Commissioner's jurisdiction; and to enable the Commissioner to use a flexible system of examinations that directs resources that are appropriate and necessary for the administration of the insurance statutes and rules of this State.

(b) As used in this section, G.S. 58-2-132 and G.S. 58-2-133, unless the context clearly indicates otherwise:

(1) "Commissioner" includes an authorized representative or designee of the Commissioner.

(2) "Examination" means an examination conducted under the Examination Law.

(3) "Examiner" means any person authorized by the Commissioner to conduct an examination.

(4) "Insurance regulator" means the official or agency of another jurisdiction that is responsible for the regulation of a foreign or alien insurer.

(5) "Person" includes a trust or any affiliate of a person.

(c) Before licensing any person to write insurance in this State, the Commissioner shall be satisfied, by such examination and evidence as the Commissioner decides to make and require, that the person is otherwise duly qualified under the laws of this State to transact business in this State.

(d) The Commissioner may conduct an examination of any insurer whenever the Commissioner deems it to be prudent for the protection of policyholders but shall at a minimum conduct an examination of every domestic insurer not less frequently than once every three years. In scheduling and determining the nature, scope, and frequency of examinations, the Commissioner shall consider such matters as the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified public accountants, and other criteria as set forth in the NAIC Examiners' Handbook.

(e) To complete an examination of any insurer, the Commissioner may authorize an examination or investigation of any person, or the business of any person, insofar as the examination or investigation is necessary or material to the insurer under examination.

(f) Instead of examining any foreign or alien insurer licensed in this State, the Commissioner may accept an examination report on that insurer prepared by the insurer's domiciliary insurance regulator. In making a determination to accept the domiciliary insurance regulator's report, the Commissioner may consider whether (i) the insurance regulator was at the time of the examination accredited under NAIC Financial Regulation Standards and Accreditation Program, or (ii) the examination is performed under the supervision of an NAIC-accredited insurance regulator or with the participation of one or more examiners who are employed by the regulator and who, after a review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by the regulator.

(g) If it appears that the insurer is of good financial and business standing and is solvent, and it is certified in writing and attested by the seal, if any, of the insurer's insurance regulator that it has been examined by the regulator in the manner prescribed by its laws, and was by the examination found to be in sound condition, that there is no reason to doubt its solvency, and that it is still permitted under the laws of such jurisdiction to do business therein, then, in the Commissioner's discretion, further examination may be dispensed with, and the obtained information and the furnished certificate may be accepted as sufficient evidence of the solvency of the insurer.

(h) Upon determining that an examination should be conducted, the Commissioner shall issue a notice of examination appointing one or more examiners to perform the examination and instructing them about the scope of the examination. In conducting the examination, an examiner shall observe the guidelines and procedures in the NAIC Examiners' Handbook. The Commissioner may also use such other guidelines or procedures as the Commissioner deems to be appropriate.

(i) Every person from whom information is sought and its officers, directors, and agents must provide to the Commissioner timely, convenient, and free access, at all reasonable hours at its offices, to all data relating to the property, assets, business, and affairs of the insurer being examined. The officers, directors, employees, and agents of the person must facilitate and aid in the examination. The refusal of any insurer, by its officers, directors, employees, or agents, to submit to examination or to comply with any reasonable written request of the Commissioner or to knowingly or willfully make any false statement in regard to the examination or written request, is grounds for revocation, suspension, refusal, or nonrenewal of any license or authority held by the insurer to engage in an insurance or other business subject to the Commissioner's jurisdiction.

(j) The Commissioner may issue subpoenas, administer oaths, and examine under oath any person about any matter pertinent to the examination. Upon the failure or refusal of any person to obey a subpoena, the Commissioner may petition the Superior Court of Wake County, and upon proper showing the Court may enter any order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the Court order is punishable as contempt of court.

(k) When making an examination, the Commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals and specialists as examiners.

(*l*) Pending, during, and after the examination of any insurer the Commissioner shall not make public the financial statement, findings, or examination report, or any report affecting the status or standing of the insurer examined, until the insurer has either accepted and approved the final examination report or has been given a reasonable opportunity to be heard on the report and to answer or rebut any statements or findings in the report. The hearing, if requested, shall be informal and private.

(m) Nothing in the Examination Law limits the Commissioner's authority to terminate or suspend any examination in order to pursue other legal or regulatory action under the laws and rules of this State and to use any final or preliminary examination report, any examiner or insurer work papers or other documents, or any other information discovered or developed during any examination in the furtherance of any legal or regulatory action that the Commissioner may consider to be appropriate. Findings of fact and conclusions made pursuant to any examination are prima facie evidence in any legal or regulator action. (1991, c. 681, s. 2; 1995, c. 360, s. 2(c); c. 517, s. 1.)

Editor's Note. — Session Laws 1995, c. 517, s. 41, contains a severability clause.

§ 58-2-133. Conflict of interest; cost of examinations; immunity from liability.

(a) No person may be appointed as an examiner by the Commissioner if that person, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination. This section does not preclude an examiner from being:

(1) A policyholder or claimant under an insurance policy;
(2) A grantor of a mortgage or similar instrument on the examiner's residence to an insurer if done under customary terms and in the ordinary course of business;
(3) An investment owner in shares of regulated diversified investment companies; or
(4) A settler or beneficiary of a blind trust into which any otherwise nonpermissible holdings have been placed.

(b) Notwithstanding the requirements of G.S. 58-2-131, the Commissioner may retain from time to time, on an individual basis, qualified actuaries, certified public accountants, or other similar individuals who are independently practicing their professions, even though they may from time to time be similarly employed or retained by persons subject to examination under the Examination Law.

(c) The refusal of any insurer to submit to examination is grounds for the revocation, suspension, or refusal of a license. The Commissioner may make public any such revocation, suspension, or refusal of license and may give reasons for that action.

(d) The provisions of G.S. 58-2-160 apply to examinations conducted under the Examination Law. (1991, c. 681, s. 2; 1995, c. 360, s. 2(d).)

§ 58-2-145: Repealed by Session Laws 1997-362, s. 7, effective December 1, 1997.

§ 58-2-161. False statement to procure or deny benefit of insurance policy or certificate.

(a) For the purposes of this section:

(1) "Insurer" includes an entity under Articles 49 and 65 through 67 of this Chapter, the Teachers' and State Employees' Comprehensive Major Medical Plan under Chapter 135 of the General Statutes, and an employer or group of employers that insure its workers' compensation liability under Chapter 97 of the General Statutes.

(2) "Statement" includes any application, notice, statement, proof of loss, bill of lading, receipt for payment, invoice, account, estimate of property damages, bill for services, diagnosis, prescription, hospital or doctor records, X rays, test result, or other evidence of loss, injury, or expense.

(b) Any person who, with the intent to injure, defraud, or deceive an insurer or insurance claimant:

(1) Presents or causes to be presented a written or oral statement, including computer-generated documents as part of, in support of, or in opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains false or misleading information concerning any fact or matter material to the claim, or

(2) Assists, abets, solicits, or conspires with another person to prepare or make any written or oral statement that is intended to be presented to an insurer or insurance claimant in connection with, in support of, or in opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains false or misleading information concerning a fact or matter material to the claim

is guilty of a Class H felony. Each claim shall be considered a separate count. Upon conviction, if the court imposes probation, the court may order the defendant to pay restitution as a condition of probation. In determination of the amount of restitution pursuant to G.S. 15A-1343(d), the reasonable costs and attorneys' fees incurred by the victim in the investigation of, and efforts to recover damages arising from, the claim, may be considered part of the damage caused by the defendant arising out of the offense.

In a civil cause of action for recovery based upon a claim for which a defendant has been convicted under this section, the conviction may be entered into evidence against the defendant. The court may award the prevailing party compensatory damages, attorneys' fees, costs, and reasonable investigative costs. If the prevailing party can demonstrate that the defendant has engaged in a pattern of violations of this section, the court may award treble damages. (1899, c. 54, s. 60; Rev., s. 3487; 1913, c. 89, s. 28; C.S., s. 4369; 1937, c. 248; 1967, c. 1088, s. 1; 1979, c. 760, s. 5; 1989 (Reg. Sess., 1990), c. 1054, s. 2; 1995, c. 43, s. 1.)

Editor's Note. —

Session Laws 1995, c. 43, s. 1, which amended this section, was effective October 1, 1995 and applicable to violations occurring on or after that date.

§ 58-2-162. Embezzlement by insurance agents, brokers, or administrators.

If any insurance agent, broker, or administrator embezzles or fraudulently converts to his own use, or, with intent to use or embezzle, takes, secretes, or otherwise disposes of, or fraudulently withholds, appropriates, lends, invests, or otherwise uses or applies any money, negotiable instrument, or other consideration received by him in his performance as an agent, broker, or administrator, he shall be guilty of a felony. If the value of the money, negotiable instrument, or other consideration is one hundred thousand dollars ($100,000) or more, violation of this section is a Class C felony. If the value of the money, negotiable instrument, or other consideration is less than one hundred thousand dollars ($100,000), violation of this section is a Class H felony. (1889, c. 54, s. 103; Rev., s. 3489; 1911, c. 196, s. 8; C.S., s. 4274; 1989 (Reg. Sess., 1990), c. 1054, s. 2; 1997-443, s. 19.25(n).)

Editor's Note. —

Session Laws 1997-443, s. 1.1, provides: "This act shall be known as 'The Current Operations and Capital Improvements Appropriations Act of 1997'".

Session Laws 1997-443, s. 35.4, is a severability clause.

Effect of Amendments. — The 1997 amendment, effective December 1, 1997, substituted "guilty of a felony" for "punished as a Class H felon" and added the last two sentences.

§ 58-2-165. Annual, semiannual, monthly, or quarterly statements to be filed with Commissioner.

CASE NOTES

Cited in State ex rel. Comm'r of Ins. v. North Carolina Rate Bureau, 124 N.C. App. 674, 478 S.E.2d 794 (1996).

§ 58-2-171. Qualifications of actuaries.

The Commissioner may adopt rules setting forth requisite qualifications of consulting actuaries for the sole purpose of qualifying them to certify financial statements filed and rate filings made by entities under this Chapter as to the actuarial validity of those filings. The qualifications shall be commensurate with the degree of complexity of the actuarial principles applicable to the various statements filed or rate filings made. Nothing in this section affects the scope of practice or the professional qualifications of actuaries. (1995, c. 517, s. 2.)

Editor's Note. — Session Laws 1995, c. 517, s. 42, made this section effective upon ratification. The Act was ratified July 29, 1995.

Session Laws 1995, c. 517, s. 41, contains a severability clause.

§ 58-2-195. Commissioner may require records, reports, etc., for agencies, agents and others.

(a) The Commissioner is empowered to make and promulgate reasonable rules and regulations governing the recording and reporting of insurance business transactions by insurance agencies, agents, brokers and producers of record, any of which agencies, agents, brokers or producers of record are licensed in this State or are transacting insurance business in this State to the end that such records and reports will accurately and separately reflect the insurance business transactions of such agency, agent, broker or producer of record in this State. Information from records required to be kept pursuant to the provisions of this section must be furnished the Commissioner on demand and the original records required to be kept pursuant to the provisions of this section shall be open to the inspection for the Commissioner or any other authorized employee described in G.S. 58-2-25 when demanded.

(b) Every insurance agency transacting insurance business in this State shall at all times have appointed some person employed or associated with such agency who shall have the responsibility of seeing that such records and reports as are required pursuant to the provisions of this section are kept and maintained.

(c) Any person subject to the provisions of subsection (a) of this section who violates the provisions of this section or the rules and regulations prescribed by the Commissioner pursuant to the provisions of this section may after notice and hearing: for the first offense have his license or licenses (in case license be issued for more than one company in such person's case) suspended or revoked for not less than one month nor more than six months and for the second offense shall have his license or licenses (in case license be issued from more than one company in his case) suspended or revoked for the period of one year and such person shall not thereafter be licensed for one year from the date said revocation or suspension first became effective.

(d) For the purpose of enforcing the provisions of this section the Commissioner or any other authorized employee described in G.S. 58-2-25 is authorized and empowered to examine persons, administer oaths and require production of papers and records relative to this section.

(e) Whenever the Commissioner deems it to be prudent for the protection of policyholders in this State, he or any other authorized employee described in G.S. 58-2-25 shall visit and examine any insurance agency, agent, broker, adjuster, motor vehicle damage appraiser, or producer of record. The refusal of any agency, agent, broker, adjuster, motor vehicle damage appraiser, or producer of record to submit to examination is grounds for the revocation or refusal of a license. (1971, c. 948, s. 1; 1987, c. 629, ss. 14, 15; c. 752, s. 1; 1995, c. 360, s. 2(e).)

§ 58-2-215. Consumer Protection Fund.

(a) A special fund is created in the Office of the State Treasurer, to be known as the Department of Insurance Consumer Protection Fund. The Fund shall be placed in an interest bearing account and any interest or other income derived from the Fund shall be credited to the Fund. Moneys in the Fund shall only be spent pursuant to warrants drawn by the Commissioner on the Fund through the State Treasurer. The Fund shall be subject to the provisions of the Executive Budget Act; except that the provisions of Article 3C of Chapter 143 of the General Statutes do not apply to subdivision (b)(1) of this section.

(b) All moneys credited to the Fund shall be used only to pay the following expenses incurred by the Department:

(1) For the purpose of retaining outside actuarial and economic consultants, legal counsel, and court reporting services in the review and analysis of rate filings, in conducting all hearings, and through any final adjudication.

(2) In connection with any delinquency proceeding under Article 30 of this Chapter, for the purpose of locating and recovering the assets of or any other obligations or liabilities owed to or due an insurer that has been placed under such proceeding.

(3) In connection with any civil litigation, other than under Chapter 150B of the General Statutes or any appeal from an order of the Commissioner or his deputies, that is commenced against the Commissioner or his deputies and that arises out of the performance of their official duties, for the purpose of retaining outside consultants, legal counsel, and court reporting services to defend such litigation.

(c) Moneys appropriated by the General Assembly shall be deposited in the Fund and shall become a part of the continuation budget of the Department of Insurance. Such continuation budget amount shall equal the actual expenditures drawn from the Fund during the prior fiscal year plus the official inflation rate designated by the Director of the Budget in the preparation of the State Budget for each ensuing fiscal year; provided that if interest income on the Fund exceeds the amount yielded by the application of the official inflation rate, such continuation budget amount shall be the actual expenditures drawn from the Fund, except that the appropriation for the 1995-96 fiscal year shall not exceed the sum of seven hundred fifty thousand dollars ($750,000) and for the 1996-97 fiscal year shall not exceed the sum of two hundred fifty thousand dollars ($250,000). In the event the amount in the Fund exceeds two hundred fifty thousand dollars ($250,000) at the end of any fiscal year, beginning with the 1995-96 fiscal year, such excess shall revert to the General Fund.

(d) Repealed by Session Laws 1996, c. 507, s. 11A(a), (b), effective July 1, 1996. (1989 (Reg. Sess., 1990), c. 1069, s. 22; 1993 (Reg. Sess., 1994), c. 769, s. 14.1; 1995, c. 507, s. 11A(a), (b).)

Editor's Note. —

Session Laws 1995, c. 507, s. 1.1, provides this act shall be known and cited as the Expansion and Capital Improvements Appropriations Act of 1995.

Session Laws 1995, c. 507, s. 28.12 is a severability clause.

Session Laws 1995, c. 507, s. 28.9, provides: "Except for statutory changes or other provisions that clearly indicate an intention to have effects beyond the 1995-97 fiscal biennium, the textual provisions of this act apply only to funds appropriated for, and activities occurring during, the 1995-97 biennium."

Session Laws 1995, c. 507, s. 11A(c), amended Session Laws 1989 (Reg. Sess., 1990), c. 1069, s. 31, deleting the last sentence regarding the expiration of amendments to the General Statutes by Session Laws 1989 (Reg. Sess., 1990), c. 1069, if the legislature did not appropriate or transfer funds. Session Laws 1989 (Reg. Sess., 1990), s. 31, as amended by Session Laws 1995, c. 507, s. 11A(c), provides: "Section 23 [See § 58-36-70] of this act does not apply to the 1990 automobile rate filing made pursuant to Article 36 of Chapter 58 of the General Statutes. Section 27 of this act [§ 143-3.6] shall expire at the end of the 1993-1994 fiscal year and Section 28 [§ 143-3.7] shall become effective upon the expiration of Section 27."

Effect of Amendments. — Session Laws 1995, c. 507, s. 11A(b), effective July 1, 1996, repealed subsection (d), limiting the amount of the Fund allocated or spent for a purpose under subsection (b).

§ 58-2-225: Repealed by Session Laws 1995, c. 193, s. 8, effective June 7, 1995.

Editor's Note. — Session Laws 1995, c. 193, s. 67 contains a severability clause.

Article 3.

General Regulations for Insurance.

§ 58-3-1. State law governs insurance contracts.

CASE NOTES

Cited in Martin v. Continental Ins. Co., 123 N.C. App. 650, 474 S.E.2d 146 (1996).

§ 58-3-10. Statements in application not warranties.

CASE NOTES

I. In General.

I. IN GENERAL.

Applied in Tharrington v. Sturdivant Life Ins. Co., 115 N.C. App. 123, 443 S.E.2d 797 (1994).

§ 58-3-50. Companies must do business in own name; emblems, insignias, etc.

Every insurance company or group of companies must conduct its business in the State in, and the policies and contracts of insurance issued by it shall be headed or entitled only by, its proper or corporate name or names. There shall not appear on the policy anything that would indicate that it is the obligation of any other than the company or companies responsible for the payment of losses under the policy, though it will be permissible to stamp or print on the policy, the name or names of the department or general agency issuing the same, and the group of companies with which the company is financially affiliated. The use of any emblem, insignia, or anything other than the true and proper corporate name of the company or group of companies shall be permitted only with the approval of the Commissioner. (1899, c. 54, s. 18; Rev., s. 4811; C.S., s. 6292; 1945, c. 377; 1951, c. 781, s. 10; 1995, c. 193, s. 9.)

Editor's Note. — Session Laws 1995, c. 193, s. 67 contains a severability clause.

§ 58-3-90. Revocation, suspension, or restriction of license of foreign company; publication of notice.

(a) If the Commissioner, upon examination or other evidence, makes a written finding of fact that a foreign insurance company is in an unsound financial condition; or, if a life insurance company, that its actual funds, exclusive of its capital, are less than its liabilities; or that the company has failed to comply with the statutes, rules, or orders applicable to it; or if the company, its officers, employees, agents, or other representatives refuse to submit to examination or to perform any legal obligation in relation to an examination, the Commissioner shall revoke or suspend all licenses and authority to do business granted to the company or its agents, and shall give written notification of the revocation or suspension to all of the company's agents in this State. Until the Commissioner restores the company's license and authority to do business in this State, neither the company nor its agents shall do any new business in this State.

(b) The Commissioner may, after considering the standards under G.S. 58-30-60(b), restrict a foreign insurer's license by prohibiting or limiting the kind or amount of insurance written by that insurer in this State. The Commissioner shall remove any restriction under this subsection once the Commissioner determines that the operations of the insurer are no longer hazardous to the public or to the insurer's policyholders or creditors. (1899, c. 54, s. 14; 1901, c. 176, s. 1; Rev., s. 4701; C.S., s. 6295; 1991, c. 720, s. 4; 1993 (Reg. Sess., 1994), c. 678, s. 5; 1995, c. 517, s. 3.)

Editor's Note. — Session Laws 1995, c. 517, s. 41, contains a severability clause.

§ 58-3-100. Revocation, suspension and refusal to renew license.

(a) The Commissioner may revoke, suspend, or refuse to renew the license of any insurer if:

(1) The insurer fails or refuses to comply with any law, order or rule applicable to the insurer.

(2) The insurer's financial condition is unsound, or its assets above its liabilities, exclusive of capital, are less than the amount of its capital or required minimum surplus.

(3) The insurer has published or made to the Department or to the public any false statement or report.

(4) The insurer refuses to submit to any examination authorized by law.

(5) The insurer is found to make a practice of unduly engaging in litigation or of delaying the investigation of claims or the adjustment or payment of valid claims.

(b) Any suspension, revocation or refusal to renew an insurer's license under this section may also be made applicable to the license or registration of any natural person regulated under this Chapter who is a party to any of the causes for licensing sanctions listed in subsection (a) of this section.

(c) The Commissioner may impose a civil penalty under G.S. 58-2-70 if an insurer fails to acknowledge a claim within 30 days after receiving written notice of the claim, but only if the notice contains sufficient information for the insurer to identify the specific coverage involved. Acknowledgement of the claim shall be made to the claimant or his legal representative advising that the claim is being investigated; or shall be a payment of the claim; or shall be a bona fide written offer of settlement; or shall be a written denial of the claim. (1899, c. 54, ss. 66, 75, 112; 1901, c. 391, s. 5; Rev., ss. 4703, 4705; C.S., s. 6297; 1947, c. 721; 1963, c. 1234; 1993, c. 409, s. 1; 1995, c. 193, s. 10.)

Editor's Note. — Session Laws 1995, c. 193, s. 67 contains a severability clause.

§ 58-3-121. Discrimination against coverage of certain bones and joints prohibited.

(a) Discrimination against coverage of procedures involving bones or joints of the jaw, face, or head is prohibited in any health benefit plan. Whenever a health benefit plan provides coverage on a group or individual basis for diagnostic, therapeutic, or surgical procedures involving bones or joints of the human skeletal structure, that plan may not exclude or deny the same coverage for procedures involving any bone or joint of the jaw, face, or head, so long as the procedure is medically necessary to treat a condition which prevents normal functioning of the particular bone or joint involved and the condition is caused by congenital deformity, disease, or traumatic injury. The coverage required by this section involving bones or joints of the jaw, face, or head shall be subject to the same conditions and limitations as are applicable to coverage of procedures involving other bones and joints of the human skeletal structure.

(b) For purposes of this section, in providing coverage for the treatment of conditions of the jaw (temporomandibular joint), authorized therapeutic procedures shall include splinting and use of intraoral prosthetic appliances to reposition the bones. Payment for these therapeutic procedures, and for procedures involved in any other nonsurgical treatment of temporomandibular joint dysfunction, may be subjected to a reasonable lifetime maximum dollar amount. Nothing in this subsection shall require a health benefit plan to cover orthodontic braces, crowns, bridges, dentures, treatment for periodontal disease, dental root form implants, or root canals.

(c) For purposes of this section, "health benefit plan" means accident and health insurance policies or certificates; nonprofit hospital or medical service corporation contracts; health, hospital, or medical service corporation plan contracts; health maintenance (HMO) subscriber contracts; and plans provided by a MEWA or plans provided by other benefit arrangements, to the extent permitted by ERISA. (1995, c. 483, s. 1.)

Editor's Note. — Session Laws 1995, c. 483, s. 2, provides that this section is effective January 1, 1996, and is applicable to all health benefit plans that are delivered, issued for delivery, or renewed on and after that date, and that renewal is presumed to occur on each anniversary of the date when coverage was first effective on the person or persons covered by the plan.

§ 58-3-150. Forms to be approved by Commissioner.

CASE NOTES

Cited in North Carolina Life & Accident & Health Ins. Guar. Ass'n v. Alcatel, 876 F. Supp. 748 (E.D.N.C. 1995).

§ 58-3-152. Excess liability policies; uninsured and underinsured motorist coverages.

With respect to policy forms that provide excess liability coverage, an insurer may limit or exclude coverage for uninsured motorists as provided in G.S. 20-279.21(b)(3) and for underinsured motorists as provided in G.S. 20-279.21(b)(4). (1997-396, s. 1.)

Editor's Note. — Session Laws 1997-396, s. 4, made this section effective August 14, 1997.

§ 58-3-168. Coverage for postmastectomy inpatient care.

(a) Every entity providing a health benefit plan that provides coverage for mastectomy, including coverage for postmastectomy inpatient care, shall ensure that the decision whether to discharge the patient following mastectomy is made by the attending physician in consultation with the patient, and shall further ensure that the length of postmastectomy hospital stay is based on the unique characteristics of each patient taking into consideration the health and medical history of the patient.

(b) As used in this section, "health benefit plans" means accident and health insurance policies or certificates; nonprofit hospital or medical service corporation contracts; health, hospital, or medical service corporation plan contracts; health maintenance organization (HMO) subscriber contracts; and plans provided by a MEWA or plans provided by other benefit arrangements, to the extent permitted by ERISA.

(c) As used in this section, "mastectomy" means the surgical removal of all or part of a breast as a result of breast cancer or breast disease. (1997-440, s. 1.)

Editor's Note. — Session Laws 1997-440, s. 2, made this section effective August 28, 1997, and applicable to health benefit plans issued, renewed, or amended on and after that date.

Session Laws 1997-440, s. 1, enacted as § 58-3-171.1 was codified as this section at the direction of the Revisor of Statutes.

§ 58-3-169. Required coverage for minimum hospital stay following birth.

(a) Definitions. — As used in this section:

(1) "Attending providers" includes:
   a. The obstetrician-gynecologists, pediatricians, family physicians, and other physicians primarily responsible for the care of a mother and newborn; and
   b. The nurse midwives and nurse practitioners primarily responsible for the care of a mother and her newborn child in accordance with State licensure and certification laws.

(2) "Health benefit plan" means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. "Health benefit plan" does not mean any of the following kinds of insurance:
   a. Accident,
   b. Credit,
   c. Disability income,
   d. Long-term or nursing home care,
   e. Medicare supplement,
   f. Specified disease,
   g. Dental or vision,
   h. Coverage issued as a supplement to liability insurance,
   i. Workers' compensation,
   j. Medical payments under automobile or homeowners, and
   k. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

l. Hospital income or indemnity.

(3) "Insurer" means an insurance company subject to this Chapter, a service corporation organized under Article 65 of this Chapter, a health maintenance organization organized under Article 67 of this Chapter, and a multiple employer welfare arrangement subject to Article 49 of this Chapter.

(b) In General. — Except as provided in subsection (c) of this section, an insurer that provides a health benefit plan that contains maternity benefits, including benefits for childbirth, shall ensure that coverage is provided with respect to a mother who is a participant, beneficiary, or policyholder under the plan and her newborn child for a minimum of 48 hours of inpatient length of stay following a normal vaginal delivery, and a minimum of 96 hours of inpatient length of stay following a cesarean section, without requiring the attending provider to obtain authorization from the insurer or its representative.

(c) Exception. — Notwithstanding subsection (b) of this section, an insurer is not required to provide coverage for postdelivery inpatient length of stay for a mother who is a participant, beneficiary, or policyholder under the insurer's health benefit plan and her newborn child for the period referred to in subsection (b) of this section if:

(1) A decision to discharge the mother and her newborn child before the expiration of the period is made by the attending provider in consultation with the mother; and

(2) The health benefit plan provides coverage for postdelivery follow-up care as described in subsections (d) and (e) of this section.

(d) Postdelivery Follow-Up Care. — In the case of a decision to discharge a mother and her newborn child from the inpatient setting before the expiration of 48 hours following a normal vaginal delivery or 96 hours following a cesarean section, the health benefit plan shall provide coverage for timely postdelivery care. This health care shall be provided to a mother and her newborn child by a registered nurse, physician, nurse practitioner, nurse midwife, or physician assistant experienced in maternal and child health in:

(1) The home, a provider's office, a hospital, a birthing center, an intermediate care facility, a federally qualified health center, a federally qualified rural health clinic, or a State health department maternity clinic; or

(2) Another setting determined appropriate under federal regulations promulgated under Title VI of Public Law 104-204.

The attending provider in consultation with the mother shall decide the most appropriate location for follow-up care.

(e) Timely Care. — As used in subsection (d) of this section, "timely postdelivery care" means health care that is provided:

(1) Following the discharge of a mother and her newborn child from the inpatient setting; and

(2) In a manner that meets the health care needs of the mother and her newborn child, that provides for the appropriate monitoring of the conditions of the mother and child, and that occurs not later than the 72-hour period immediately following discharge.

(f) Prohibitions. — An insurer shall not:

(1) Deny enrollment, renewal, or continued coverage with respect to its health benefit plan to a mother and her newborn

child who are participants, beneficiaries, or policyholders, based on compliance with this section;

(2) Provide monetary payments or rebates to mothers to encourage the mothers to request less than the minimum coverage required under this section;

(3) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider provided treatment to an individual policyholder, participant, or beneficiary in accordance with this section; or

(4) Provide monetary or other incentives to an attending provider to induce the provider to provide treatment to an individual policyholder, participant, or beneficiary in a manner inconsistent with this section.

(g) Effect on Mother. — Nothing in this section requires that a mother who is a participant, beneficiary, or policyholder covered under this section:

(1) Give birth in a hospital; or

(2) Stay in the hospital for a fixed period of time following the birth of her child.

(h) Level and Type of Reimbursements. — Nothing in this section prevents an insurer from negotiating the level and type of reimbursement with an attending provider for care provided in accordance with this section. (1997-259, s. 19.)

Editor's Note. — Session Laws 1997-259, s. 26, made this section effective July 1, 1997.

Session Laws 1997-259, s. 25, provides: "Sections 1 through 18 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after July 1, 1997. Sections 19, 20, 21, 22, and 23 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after January 1, 1998. For the purposes of this act, renewal of a contract is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the contract."

§ 58-3-170. Requirements for maternity coverage.

(a) Every entity providing a health benefit plan that provides maternity coverage in this State shall provide benefits for the necessary care and treatment related to maternity that are no less favorable than benefits for physical illness generally.

(a1) Repealed by Session Laws 1997-259, s. 20, effective July 1, 1997.

(b) As used in this section, "health benefit plans" means accident and health insurance policies or certificates; nonprofit hospital or medical service corporation contracts; health, hospital, or medical service corporation plan contracts; health maintenance organization (HMO) subscriber contracts; and plans provided by a MEWA or plans provided by other benefit arrangements, to the extent permitted by ERISA. (1993, c. 506, s. 2; 1995, c. 517, s. 3.1; 1997-259, s. 20.)

Editor's Note. —

Session Laws 1995, c. 517, s. 41, contains a severability clause.

The subsection (a1) designation was assigned at the direction of the Revisor of Statutes, the designation in Session Laws 1995, c. 517, s. 3.1 having been (b).

Session Laws 1995, c. 517, s. 3.1, which amended this section, was effective October 1, 1995, and applicable to health benefit plans issued, renewed, or amended on or after that date.

Session Laws 1997-259, s. 25, provides: "Sections 1 through 18 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after July 1, 1997. Sections 19, 20, 21, 22, and 23 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after January 1, 1998. For the purposes of this act, renewal of a contract is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the contract."

Effect of Amendments. — The 1997 amendment, effective July 1, 1997, repealed subsection (a1), concerning coverage for mothers and newly born children. For applicability, see Editor's Note.

§ 58-3-173: Repealed by Session Laws 1997-259, s. 24, effective July 1, 1997.

§ 58-3-176. Treatment discussions not limited.

(a) An insurer shall not limit either of the following:

(1) The participating plan provider's ability to discuss with an enrollee the clinical treatment options medically available, the risks associated with the treatments, or a recommended course of treatment.

(2) The participating plan provider's professional obligations to patients as specified under the provider's professional license.

(b) Nothing in this section shall be construed to expand or revise the scope of benefits covered by a health benefit plan.

(c) As used in this section:

(1) "Health benefit plan" means any of the following if written by an insurer: an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; or a plan provided by a multiple employer welfare arrangement. "Health benefit plan" does not mean any plan implemented or administered through the Department of Health and Human Services or its representatives. "Health benefit plan" also does not mean any of the following kinds of insurance:

a. Accident.
b. Credit.
c. Disability income.
d. Long-term or nursing home care.
e. Medicare supplement.
f. Specified disease.
g. Dental or vision.
h. Coverage issued as a supplement to liability insurance.
i. Workers' compensation.
j. Medical payments under automobile or homeowners insurance.
k. Hospital income or indemnity.
l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

(2) "Insurer" means an entity that writes a health benefit plan and that is an insurance company subject to this Chapter, a service corporation under Article 65 of this Chapter, a health maintenance organization under Article 67 of this Chapter, or a multiple employer welfare arrangement un-

der Article 49 of this Chapter. (1997-443, s. 11A.122; 1997-474, s. 1.)

Editor's Note. — Session Laws 1997-474, s. 5, made this section effective September 3, 1997.

Session Laws 1997-443, s. 35.4, is a severability clause.

Effect of Amendments. — Session Laws 1997-443, s. 11A.122, effective August 28, 1997, substituted "Health and Human Services" for "Human Resources" in subdivision (c)(1).

§ 58-3-185. Lien created for payment of past-due child support obligations.

(a) In the event that the Department of Health and Human Services or any other obligee, as defined in G.S. 110-129, provides written notification to an insurance company authorized to issue policies of insurance pursuant to this Chapter that a claimant or beneficiary under a contract of insurance owes past-due child support and accompanies this information with a certified copy of the court order ordering support together with proof that the claimant or beneficiary is past due in meeting this obligation, there is created a lien upon any insurance proceeds in favor of the Department or obligee. This section shall apply only in those instances in which there is a nonrecurring payment of a lump-sum amount equal to or in excess of three thousand dollars ($3,000) or periodic payments with an aggregate amount that equals or exceeds three thousand dollars ($3,000).

(b) Liens arising under this section shall be subordinate to liens upon insurance proceeds for personal injuries arising under Article 9 of Chapter 44 of the General Statutes and valid health care provider claims covered by health benefit plans as defined in G.S. 58-3-172. As used in this section, the term health benefit plans does not include disability income insurance. (1995, c. 538, s. 6(a); 1995 (Reg. Sess., 1996), c. 674, ss. 1, 2; 1997-443, s. 11A.118(a).)

Editor's Note. — Session Laws 1995, c. 538, s. 6, made this section (enacted as G.S. 44-49.1) effective July 1, 1996, and applicable to child support owed on or after that date.

Session Laws 1997-443, s. 1.1, provides: "This act shall be known as 'The Current Operations and Capital Improvements Appropriations Act of 1997'".

Session Laws 1997-443, s. 35.4, is a severability clause.

Effect of Amendments. — Session Laws 1995 (Reg. Sess., 1996), c. 674, ss. 1, 2, effective July 1, 1996, recodified former G.S. 44-49.1 as this section; added the subsection (a) designation; and added subsection (b).

The 1997 amendment, effective August 28, 1997, substituted "Health and Human Services" for "Human Resources."

§§ 58-3-186 through 58-3-189: Reserved for future codification purposes.

§ 58-3-190. Coverage required for emergency care.

(a) Every insurer shall provide coverage for emergency services to the extent necessary to screen and to stabilize the person covered under the plan and shall not require prior authorization of the services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. Payment of claims for emergency services shall be based on the retrospective review of the presenting history and symptoms of the covered person.

(b) With respect to emergency services provided by a health care provider who is not under contract with the insurer, the services shall be covered if:

(1) A prudent layperson acting reasonably would have believed that a delay would worsen the emergency, or

(2) The covered person did not seek services from a provider under contract with the insurer because of circumstances beyond the control of the covered person.

(c) An insurer that has given prior authorization for emergency services shall cover the services and shall not retract the authorization after the services have been provided unless the authorization was based on a material misrepresentation about the covered person's health condition made by the provider of the emergency services or the covered person.

(d) Coverage of emergency services shall be subject to coinsurance, co-payments, and deductibles applicable under the health benefit plan. An insurer shall not impose cost-sharing for emergency services provided under this section that differs from the cost-sharing that would have been imposed if the physician or provider furnishing the services were a provider contracting with the insurer.

(e) Both the emergency department and the insurer shall make a good faith effort to communicate with each other in a timely fashion to expedite postevaluation or poststabilization services in order to avoid material deterioration of the covered person's condition within a reasonable clinical confidence, or with respect to a pregnant woman, to avoid material deterioration of the condition of the unborn child within a reasonable clinical confidence.

(f) Insurers shall provide information to their covered persons on all of the following:

(1) Coverage of emergency medical services.

(2) The appropriate use of emergency services, including the use of the "911" system and other telephone access systems utilized to access prehospital emergency services.

(3) Any cost-sharing provisions for emergency medical services.

(4) The process and procedures for obtaining emergency services, so that covered persons are familiar with the location of in-plan emergency departments and with the location and availability of other in-plan settings at which covered persons may receive medical care.

(g) As used in this section, the term:

(1) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

a. Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

b. Serious impairment to bodily functions.

c. Serious dysfunction of any bodily organ or part.

(2) "Emergency services" means health care items and services furnished or required to screen for or treat an emergency

medical condition until the condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department.

(3) "Health benefit plan" means any of the following if written by an insurer: an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; or a plan provided by a multiple employer welfare arrangement. "Health benefit plan" does not mean any plan implemented or administered through the Department of Health and Human Services or its representatives. "Health benefit plan" also does not mean any of the following kinds of insurance:
a. Accident.
b. Credit.
c. Disability income.
d. Long-term or nursing home care.
e. Medicare supplement.
f. Specified disease.
g. Dental or vision.
h. Coverage issued as a supplement to liability insurance.
i. Workers" compensation.
j. Medical payments under automobile or homeowners insurance.
k. Hospital income or indemnity.
l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

(4) "Insurer" means an entity that writes a health benefit plan and that is an insurance company subject to this Chapter, a service corporation under Article 65 of this Chapter, a health maintenance organization under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 49 of this Chapter.

(5) "To stabilize" means to provide medical care that is appropriate to prevent a material deterioration of the person's condition, within reasonable medical probability, in accordance with the HCFA (Health Care Financing Administration) interpretative guidelines, policies and regulations pertaining to responsibilities of hospitals in emergency cases (as provided under the Emergency Medical Treatment and Labor Act, section 1867 of the Social Security Act, 42 U.S.C.S. 1395dd), including medically necessary services and supplies to maintain stabilization until the person is transferred. (1997-443, s. 11A.122; 1997-474, s. 2)

Editor's Note. —

Session Laws 1997-443, s. 35.4, is a severability clause.

Session Laws 1997-474, s. 2, made this section effective January 1, 1998, and applicable to health benefit plans issued, renewed, or amended on or after that date.

Effect of Amendments. — Session Laws 1997-443, s. 11A.122, effective August 28, 1997, substituted "Health and Human Services" for "Human Resources" in subdivision (g)(3).

§ 58-3-191. Managed care reporting and disclosure requirements.

(a) Each health benefit plan shall annually, on or before the first day of March of each year, file in the office of the Commissioner the following information for the previous calendar year:

(1) The number of and reasons for grievances received from plan participants regarding medical treatment. The report shall include the number of covered lives, total number of grievances categorized by reason for the grievance, the number of grievances referred to the second level grievance review, the number of grievances resolved at each level and their resolution, and a description of the actions that are being taken to correct the problems that have been identified through grievances received. Every health benefit plan shall file with the Commissioner, as part of its annual grievance report, a certificate of compliance stating that the carrier has established and follows, for each of its lines of business, grievance procedures that comply with G.S. 58-50-62.

(2) The number of participants and groups who terminated coverage under the plan for any reason. The report shall include the number of participants who terminated coverage because the group contract under which they were covered was terminated, the number of participants who terminated coverage for reasons other than the termination of the group under which they were enrolled, and the number of group contracts terminated.

(3) The number of provider contracts that were terminated and the reasons for termination. This information shall include the number of providers leaving the plan and the number of new providers. The report shall show voluntary and involuntary terminations separately.

(4) Data relating to the utilization, quality, availability, and accessibility of services. The report shall include the following:

a. Information on the health benefit plan's program to determine the level of network availability, as measured by the numbers and types of network providers, required to provide covered services to covered persons. This information shall include the plan's methodology for:

1. Establishing performance targets for the numbers and types of providers by specialty, area of practice, or facility type, for each of the following categories: primary care physicians, specialty care physicians, nonphysician health care providers, hospitals, and nonhospital health care facilities.

2. Determining when changes in plan membership will necessitate changes in the provider network.

The report shall also include: the availability performance targets for the previous and current years; the numbers and types of providers currently participating in the health benefit plan's provider network; and an evaluation of actual plan performance against performance targets.

b. The health benefit plan's method for arranging or providing health care services from nonnetwork providers, both within and outside of its service area, when network providers are not available to provide covered services.

c. Information on the health benefit plan's program to determine the level of provider network accessibility necessary to serve its membership. This information shall include the health benefit plan's methodology for establishing performance targets for member access to covered services from primary care physicians, specialty care physicians, nonphysician health care providers, hospitals, and nonhospital health care facilities. The methodology shall establish targets for:
   1. The proximity of network providers to members, as measured by member driving distance, to access primary care, specialty care, hospital-based services, and services of nonhospital facilities.
   2. Expected waiting time for appointments for urgent care, acute care, specialty care, and routine services for prevention and wellness.

   The report shall also include: the accessibility performance targets for the previous and current years; data on actual overall accessibility as measured by driving distance and average appointment waiting time; and an evaluation of actual plan performance against performance targets. Measures of actual accessibility may be developed using scientifically valid random sample techniques.

d. A statement of the health benefit plan's methods and standards for determining whether in-network services are reasonably available and accessible to a covered person, for the purpose of determining whether a covered person should receive the in-network level of coverage for services received from a nonnetwork provider.

e. A description of the health benefit plan's program to monitor the adequacy of its network availability and accessibility methodologies and performance targets, plan performance, and network provider performance.

f. A summary of the health benefit plan's utilization review program activities for the previous calendar year. The report shall include the number of: each type of utilization review performed, noncertifications for each type of review, each type of review appealed, and appeals settled in favor of covered persons. The report shall be accompanied by a certification from the carrier that it has established and follows procedures that comply with G.S. 58-50-61.

(5) Aggregate financial compensation data, including the percentage of providers paid under a capitation arrangement, discounted fee-for-service or salary, the services included in the capitation payment, and the range of compensation paid by withhold or incentive payments. This information shall be submitted on a form prescribed by the Commissioner.

The name, or group or institutional name, of an individual provider may not be disclosed pursuant to this subsection. No civil liability shall arise from compliance with the provisions of this subsection, provided that the acts or omissions are made in good faith and do not constitute gross negligence, willful or wanton misconduct, or intentional wrongdoing.

(b) Disclosure requirements. — Each health benefit plan shall provide the following applicable information to plan participants and bona fide prospective participants upon request:

(1) The evidence of coverage (G.S. 58-67-50), subscriber contract (G.S. 58-65-60, 58-65-140), health insurance policy (G.S. 58-51-80, 58-50-125, 58-50-55), or the contract and benefit summary of any other type of health benefit plan;

(2) An explanation of the utilization review criteria and treatment protocol under which treatments are provided for conditions specified by the prospective participant. This explanation shall be in writing if so requested;

(3) If denied a recommended treatment, written reasons for the denial and an explanation of the utilization review criteria or treatment protocol upon which the denial was based;

(4) The plan's restrictive formularies or prior approval requirements for obtaining prescription drugs, whether a particular drug or therapeutic class of drugs is excluded from its formulary, and the circumstances under which a nonformulary drug may be covered; and

(5) The plan's procedures and medically based criteria for determining whether a specified procedure, test, or treatment is experimental.

(b1) Effective March 1, 1998, insurers shall make the reports that are required under subsection (a) of this section and that have been filed with the Commissioner available on their business premises and shall provide any insured access to them upon request.

(c) For purposes of this section, "health benefit plan" or "plan" means (i) health maintenance organization (HMO) subscriber contracts and (ii) insurance company or hospital and medical service corporation preferred provider benefit plans in which utilization review or quality management programs are used to manage the provision of covered health care services, and enrollees are given incentives through benefit differentials to limit the receipt of covered health care services to those provided by participating providers. (1997-480, s. 1; 1997-519, s. 1.1.)

Editor's Note. — Section 58-50-55 referred to in subdivision (b)(1) has been repealed.

This section was enacted as § 58-3-190 by Session Laws 1997-480, s. 1. It was renumbered as 58-3-191 by Session Laws 1997-519, s. 1.1.

Effect of Amendments. — The 1997 amendment, effective January 1, 1988, recodified this section, which was enacted as G.S. 58-3-190, rewrote subsection (a), and added subsection (b1).

§ 58-3-200. Miscellaneous insurance and managed care coverage and network provisions.

(a) Definitions. — As used in this section:

(1) "Health benefit plan" means any of the following if written by an insurer: an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; or a plan provided by a multiple employer welfare arrangement. "Health benefit plan" does not mean

any plan implemented or administered through the Department of Health and Human Services or its representatives. "Health benefit plan" also does not mean any of the following kinds of insurance:

a. Accident.
b. Credit.
c. Disability income.
d. Long-term or nursing home care.
e. Medicare supplement.
f. Specified disease.
g. Dental or vision.
h. Coverage issued as a supplement to liability insurance.
i. Workers' compensation.
j. Medical payments under automobile or homeowners insurance.
k. Hospital income or indemnity.
l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

(2) "Insurer" means an entity that writes a health benefit plan and that is an insurance company subject to this Chapter, a service corporation under Article 65 of this Chapter, a health maintenance organization under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 49 of this Chapter.

(b) Medical Necessity. — An insurer that limits its health benefit plan coverage to medically necessary services and supplies shall define "medically necessary services or supplies" in its health benefit plan as those covered services or supplies that are:

(1) Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and not for experimental, investigational, or cosmetic purposes.
(2) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.
(3) Within generally accepted standards of medical care in the community.
(4) Not solely for the convenience of the insured, the insured's family, or the provider.

For medically necessary services, nothing in this subsection precludes an insurer from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

(c) Coverage Determinations. — If an insurer or its authorized representative determines that services, supplies, or other items are covered under its health benefit plan, including any determination under G.S. 58-50-61, the insurer shall not subsequently retract its determination after the services, supplies, or other items have been provided, or reduce payments for a service, supply, or other item furnished in reliance on such a determination, unless the determination was based on a material misrepresentation about the insured's health condition that was knowingly made by the insured or the provider of the service, supply, or other item.

(d) Services Outside Provider Networks. — No insurer shall penalize an insured or subject an insured to the out-of-network benefit levels offered under the insured's approved health benefit plan unless contracting health care providers able to meet health needs of the insured are reasonably available to the insured without unreasonable delay.

(e) Nondiscrimination Against High-Risk Populations. — No insurer shall establish provider selection or contract renewal standards or procedures that are designed to avoid or otherwise have the effect of avoiding enrolling high-risk populations by excluding providers because they are located in geographic areas that contain high-risk populations or because they treat or specialize in treating populations that present a risk of higher-than-average claims or health care services utilization. This subsection does not prohibit an insurer from declining to select a provider or from not renewing a contract with a provider who fails to meet the insurer's selection criteria.

(f) Continuing Care Retirement Community Residents. — As used in this subsection, "Medicare benefits" means medical and health products, benefits, and services used in accordance with Title XVIII of the Social Security Act. If an insured with coverage for Medicare benefits or similar benefits under a plan for retired federal government employees is a resident of a continuing care retirement community regulated under Article 64 of this Chapter, and the insured's primary care physician determines that it is medically necessary for the insured to be referred to a skilled nursing facility upon discharge from an acute care facility, the insurer shall not require that the insured relocate to a skilled nursing facility outside the continuing care retirement community if the continuing care retirement community:

(1) Is a Medicare-certified skilled nursing facility.
(2) Agrees to be reimbursed at the insurer's contract rate negotiated with similar providers for the same services and supplies.
(3) Agrees not to bill the insured for fees over and above the insurer's contract rate.
(4) Meets all guidelines established by the insurer related to quality of care, including:
   a. Quality assurance programs that promote continuous quality improvement.
   b. Standards for performance measurement for measuring and reporting the quality of health care services provided to insureds.
   c. Utilization review, including compliance with utilization management procedures.
   d. Confidentiality of medical information.
   e. Insured grievances and appeals from adverse treatment decisions.
   f. Nondiscrimination.
(5) Agrees to comply with the insurer's procedures for referral authorization, risk assumption, use of insurer services, and other criteria applicable to providers under contract for the same services and supplies.

A continuing care retirement community that satisfies subdivisions (1) through (5) of this subsection shall not be obligated to accept, as a skilled nursing facility, any patient other than a resident of the continuing care retirement community, and neither the insurer nor the retirement community shall be allowed to list or otherwise advertise the skilled nursing facility as a participating network provider for Medicare benefits for anyone other than residents of the continuing care retirement community. (1997-443, s. 11A.122; 1997-519, s. 2.1.)

Editor's Note. — Session Laws 1997-443, s. 1.1, provides "This act shall be known as "The Current Operations and Capital Improvements Appropriations Act of 1997.'"

Session Laws 1997-443, s. 35.4, is a severability clause.

Session Laws 1997-519, s. 5, made this section effective January 1, 1998. For applicability, see Editor's Note.

Session Laws 1997-519, s. 5, provides: "This act becomes effective January 1, 1998. Part II of this act applies to all health benefit plans that are delivered, issued for delivery, or renewed on or after January 1, 1998. For the purposes of this act, renewal of a health benefit plan is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the health benefit plan. Insurers other than health maintenance organizations that are subject to Part IV of this act have until July 1, 1998, to implement the procedures for grievances that are contained in Section 4.2 of Part IV of this act; provided, however, that insurers other than health maintenance organizations shall comply with the second-level grievance review procedures in Section 4.2 of Part IV of this act for appeals of noncertifications effective January 1, 1998."

Effect of Amendments. — Session Laws 1997-443, s. 11A.122, effective August 28, 1997, substituted "Health and Human Services" for "Human Resources" in subdivision (a)(1).

§ 58-3-215. Genetic information in health insurance.

(a) Definitions. — As used in this section:

(1) "Genetic information" means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member. "Genetic information" does not include the results of routine physical measurements, blood chemistries, blood counts, urine analyses, tests for abuse of drugs, and tests for the presence of human immunodeficiency virus.

(2) "Health benefit plan" means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. "Health benefit plan" does not mean any plan implemented or administered through the Department of Health and Human Services or its representatives. "Health benefit plan" also does not mean any of the following kinds of insurance:

a. Accident
b. Credit
c. Disability income
d. Long-term or nursing home care
e. Medicare supplement
f. Specified disease
g. Dental or vision
h. Coverage issued as a supplement to liability insurance
i. Workers' compensation

j. Medical payments under automobile or homeowners
k. Hospital income or indemnity
l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance
m. Blanket accident and sickness.

(3) "Insurer" means an insurance company subject to this Chapter; a service corporation organized under Article 65 of this Chapter; a health maintenance organization organized under Article 67 of this Chapter; or a multiple employer welfare arrangement subject to Article 49 of this Chapter.

(b) For the purpose of this section, routine physical measurements, blood chemistries, blood counts, urine analyses, tests for abuse of drugs, and tests for the presence of human immunodeficiency virus are not to be considered genetic tests.

(c) No insurer shall:

(1) Raise the premium or contribution rates paid by a group for a group health benefit plan on the basis of genetic information obtained about an individual member of the group.

(2) Refuse to issue or deliver a health benefit plan because of genetic information obtained about any person to be insured by the health benefit plan.

(3) Charge a higher premium rate or charge for a health benefit plan because of genetic information obtained about any person to be insured by the health benefit plan. (1997-350, s. 1; 1997-350, s. 1; 1997-443, s. 11A.118(b).)

Editor's Note. — Session Laws 1997-350, s. 4, provides: "Nothing in this act applies to specified accident, specified disease, hospital indemnity, disability, or long-term care health insurance policies."

Session Laws 1997-350, s. 5, made this section effective August 1, 1997.

Session Laws 1997-443, s. 1.1, provides: "This act shall be known as 'The Current Operations and Capital Improvements Appropriations Act of 1997'".

Session Laws 1997-443, s. 35.4, is a severability clause.

Effect of Amendments. — Session Laws 1997-443, s. 11A.118(a), effective August 28, 1997, substituted "Health and Human Services" for "Human Resources."

ARTICLE 5.

Deposits and Bonds by Insurance Companies.

§ 58-5-60: Repealed by Session Laws 1995, c. 193, s. 8, effective June 7, 1995.

Editor's Note. — Session Laws 1995, c. 193, s. 67 contains a severability clause.

§ 58-5-63. Interest; liquidation of deposits for liabilities.

(a) All insurance companies making deposits under this Article are entitled to interest on those deposits, which shall remain in the deposit accounts. The right to interest is subject to a company paying its insurance policy liabilities. If any company fails to pay those liabilities, interest accruing after the failure is payable to the Commissioner for the payment of those liabilities under subsection (b) of this section.

(b) If any company fails to pay its insurance policy liabilities after those liabilities have been established by settlement or final adjudication, the Commissioner may liquidate the amount of the company's deposit and accrued interest specified in subsection (a) of this section that will satisfy the company's policy liabilities and make payment to the person to whom the liability is owed. After payment has been made, the Commissioner may require the company to deposit the amount paid out under this subsection. (1995, c. 193, s. 11.)

Editor's Note. — Session Laws 1995, c. 193, c. 68, made this section effective upon ratification. The Act was ratified June 7, 1995.

Session Laws 1995, c. 193, s. 67 contains a severability clause.

§ 58-5-65: Repealed by Session Laws 1995, c. 193, s. 8, effective June 7, 1995.

Editor's Note. — Session Laws 1995, c. 193, s. 67 contains a severability clause.

§ 58-5-70. Lien of policyholders; action to enforce.

Upon the securities deposited with the Commissioner by any foreign or alien insurance company, the holders of all contracts of the company who are citizens or residents of this State at the time, or who hold policies issued upon property in the State, shall have a lien for the amounts due them, respectively, under or in consequence of the contracts for losses, equitable values, return premiums, or otherwise, and shall be entitled to be paid ratably out of the proceeds of the securities, if the proceeds are not sufficient to pay all of the contract holders. When any foreign or alien insurance company depositing securities under this Article becomes insolvent or bankrupt or makes an assignment for the benefit of its creditors, any holder of the contract may begin an action in the Superior Court of the County of Wake to enforce the lien for the benefit of all the holders of the contracts. The Commissioner shall be a party to the suit, and the funds shall be distributed by the court, but the cost of the action shall not be adjudged against the Commissioner. (1909, c. 923, s. 4; C.S., s. 6445; 1991, c. 720, s. 4; 1995, c. 193, s. 12.)

Editor's Note. — Session Laws 1995, c. 193, s. 67 contains a severability clause.

Article 6.

License Fees and Taxes.

§ 58-6-5. Schedule of fees and charges.

The Commissioner shall collect and pay into the State treasury fees and charges as follows:

(1) For filing and examining an insurance company application for admission, a nonrefundable fee of two hundred fifty dollars ($250.00), to be submitted with such filing; for filing and auditing annual statement, one hundred dollars ($100.00); for filing any other papers required by law, twenty-five dollars ($25.00); for each certificate of examination, condition, or qualification of company or association, fifteen dollars ($15.00); for each seal when required, ten dollars ($10.00); for a list of licensed insurance companies, ten dollars ($10.00).

(2) Repealed by Session Laws 1977, c. 376, s. 2.

(3) The Commissioner shall receive for copy of any record or paper in his office fifty cents (50) per copy sheet and ten dollars ($10.00) for certifying same, or any fact or data from the records of his office and for the examination and approval of charters of companies, twenty-five dollars ($25.00).

(4) He shall collect all other fees and charges due and payable into the State treasury by any company, association, order, or individual under his Department.

(5) The Commissioner shall charge and insurers shall pay, as a prerequisite to receipt and review by the Commissioner of filings of policy forms or rates, a fee of twenty dollars ($20.00) per policy form filed and submitted for approval; a fee of twenty dollars ($20.00) for each property or casualty rate filing submitted; and a fee of twenty dollars ($20.00) for each life, accident, or health rate filing submitted. Payment of the fee shall be made at the time the form or rate filing is submitted. All fees are nonrefundable. If an insurer fails to pay the proper fee at the time of submittal, the Commissioner shall not be required to review the form or rate filed until the insurer remits the proper fee; and any statutory time periods relating to the filing shall be tolled until the insurer remits the proper fee. As used in this subdivision, "insurer" includes an entity subject to Articles 65 through 67 of this Chapter; any rating organization, advisory organization, joint underwriting association, or joint reinsurance organization subject to Articles 1 through 64 of this Chapter; and the North Carolina Rate Bureau and the North Carolina Motor Vehicle Reinsurance Facility. As used in this subdivision, "policy form" includes an application form, a declarations page, a policy jacket, a policy or contract of insurance, or an endorsement, rider, or any amendment to a policy form that has already been approved by the Commissioner; provided that an initial policy filing made by an insurer shall constitute one policy form. (1899, c. 54, ss. 50, 68, 80, 81, 82, 87, 90, 92; 1901, c. 391, s. 7; c. 706, s. 2; 1903, c. 438, ss. 7, 8; c. 536, s. 4; cc. 680,

774; 1905, c. 588, s. 68; Rev., s. 4715; 1913, c. 140, s. 1; 1919, c. 186, s. 6; C.S., s. 6318; 1921, c. 218; 1935, c. 334; 1939, c. 158, s. 208; 1945, c. 386; 1947, c. 721; 1957, cc. 133, 1047; 1959, c. 911; 1963, c. 692; 1977, c. 376, s. 2; c. 802, s. 50; 1983, c. 790, s. 6; 1989 (Reg. Sess., 1990), c. 1069, s. 2; 1991, c. 720, s. 4; 1995, c. 360, s. 2(f).)

Editor's Note. —

Session Laws 1995, c. 507, s. 11A(c), amended Session Laws 1989 (Reg. Sess., 1990), c. 1069, s. 31, deleting the last sentence regarding the expiration of amendments to the General Statutes by Session Laws 1989 (Reg Sess., 1990), c. 1069, if the legislature did not appropriate or transfer funds. Session Laws 1989 (Reg. Sess., 1990), s. 31, as amended by Session Laws 1995, c. 507, s. 11A(c), provides : "Section 23 [§ 58-36-70] of this act does not apply to the 1990 automobile rate filing made pursuant to Article 36 of Chapter 58 of the General Statutes. Section 27 [§ 143-3.6] of this act shall expire at the end of the 1993-1994 fiscal year and Section 28 [§ 143-3.7] shall become effective upon the expiration of Section 27."

Session Laws 1995, c. 507, s. 1.1, provides that this act shall be known and cited as the Expansion and Capital Improvements Appropriations Act of 1995.

Session Laws 1995, c. 507, s. 28.9, provides: "Except for statutory changes or other provisions that clearly indicate an intention to have effects beyond the 1995-97 fiscal biennium, the textual provisions of this act apply only to funds appropriated for, and activities occurring during, the 1995-97 biennium."

§ 58-6-7. Annual license fees for insurance companies.

(a) As a condition precedent to doing business in this State, an insurance company must apply for and obtain a license from the Commissioner of Insurance by March 1 of each year. The license shall become effective the following July 1 and shall remain in effect for one year. Except as provided in subsections (b) and (c) of this section, the insurance company shall pay an annual fee for the license as follows:

For each domestic farmer's mutual assessment fire insurance company	$ 25.00
For each fraternal order	100.00
For each of all other insurance companies, except mutual burial associations taxed under G.S. 105-121.1	500.00

The fees levied in this subsection shall be in addition to those specified in G.S. 58-6-5.

(b) When the paid-in capital stock and/or surplus of an insurance company other than a farmer's mutual assessment company or a fraternal order does not exceed one hundred thousand dollars ($100,000), the fee levied in this section shall be one half the amount above specified.

(c) Upon payment of the fee specified above and the fees and taxes elsewhere specified each insurance company, exchange, bureau, or agency, shall be entitled to do the types of business specified in Chapter 58, of the General Statutes of North Carolina as amended, to the extent authorized therein, except that: Insurance companies authorized to do either the types of business specified for (i) life insurance companies, or (ii) for fire and marine companies, or (iii) for casualty and fidelity and surety companies, in G.S. 58-7-75, which shall also do the types of business authorized in one or both of the other of the above classifications shall in addition to the fees above specified pay one hundred dollars ($100.00) for each such additional classification of business done.

(d) Any rating bureau established by action of the General Assembly of North Carolina shall be exempt from the fees above levied. (1945, c. 752, s. 2; 1947, c. 501, s. 8; 1955, c. 179, s. 5; 1989 (Reg. Sess., 1990), c. 1069, s. 4; 1993, c. 495, s. 4; 1993 (Reg. Sess., 1994), c. 745, s. 12; 1995, c. 193, s. 65; c. 360, s. 1(c).)

Editor's Note. — This section is former § 105-228.4, as recodified by Session Laws 1995, c. 360, s. 1(c). The historical citation from the former section has been added to this section as recodified.

Session Laws 1995, c. 507, s. 11A(c), amended Session Laws 1989 (Reg. Sess., 1990), c. 1069, s. 31, deleting the last sentence regarding the expiration of amendments to the General Statutes by Session Laws 1989 (Reg. Sess., 1990), c. 1069, if the legislature did not appropriate or transfer funds. Session Laws 1989 (Reg. Sess., 1990), s. 31, as amended by Session Laws 1995, c. 507, s. 11A(c), provides: "Section 23 [§ 58-36-70] of this act does not apply to the 1990 automobile rate filing made pursuant to Article 36 of Chapter 58 of the General Statutes. Section 27 [§ 143-3.6] of this act shall expire at the end of the 1993-1994 fiscal year and Section 28 [§ 143-3.7] shall become effective upon the expiration of Section 27."

Session Laws 1995, c. 507, s. 1.1, provides this act shall be known and cited as the Expansion and Capital Improvements Appropriations Act of 1995.

Session Laws 1995, c. 507, s. 28.9, provides: "Except for statutory changes or other provisions that clearly indicate an intention to have effects beyond the 1995-97 fiscal biennium, the textual provisions of this act apply only to funds appropriated for, and activities occurring during, the 1995-97 biennium."

Session Laws 1995, c. 193, s. 67 contains a severability clause.

Session Laws 1989 (Reg. Sess., 1990), c. 1069, which amended this section, in s. 1 provided: "The purpose of this act is to raise revenue for the State in order for the State and the Department of Insurance to accomplish the following:

"(a) Generate a net revenue to the General Fund in an amount of approximately one million dollars for the ensuing fiscal years.

"(b) Mitigate the adverse monetary effect on the State Property Fire Insurance Fund caused by the transfer of substantial amounts from that Fund to reimburse local governments for fire protection of State property.

"(c) Eliminate the State's potential liability arising out of the case of The Aetna Casualty and Surety Company, et al, v. James E. Long, Commissioner of Insurance of the State of North Carolina, 90CV 04729, filed on April 26, 1990; provide for a premium tax credit over the next four fiscal years for the plaintiffs and other foreign insurance companies similarly situated; and cover the resulting loss of retaliatory premium tax revenue.

"(d) Create a special fund in the office of the State Treasurer for the use of the Department of Insurance (1) for retaining experts and court reporters in handling insurance ratemaking for the benefit of insurance consumers in this State; (2) for locating and recovering missing assets of and other amounts owed to insolvent insurers for the benefit of the policy owners of such insurers; and (3) for retaining legal counsel and court reporters in extraordinary civil actions commenced against the Commissioner of Insurance or his deputies that arise out of the performance of their official duties."

§ 58-6-15. Licenses run from July 1.

Editor's Note. —

Session Laws 1995, c. 507, s. 11A(c), amended Session Laws 1989 (Reg. Sess., 1990), c. 1069, s. 31, deleting the last sentence regarding the expiration of amendments to the General Statutes by Session Laws 1989 (Reg. Sess., 1990), c. 1069, if the legislature did not appropriate or transfer funds. Session Laws 1989 (Reg. Sess., 1990), s. 31, as amended by Session Laws 1995, c. 507, s. 11A(c), provides: "Section 23 [see § 58-36-70] of this act does not apply to the 1990 automobile rate filing made pursuant to Article 36 of Chapter 58 of the General Statutes. Section 27 [§ 143-3.6] of this act shall expire at the end of the 1993-1994 fiscal year and Section 28 [§ 143-3.7] shall become effective upon the expiration of Section 27."

Session Laws 1995, c. 507, s. 1.1, provides that this act shall be known and cited as the Expansion and Capital Improvements Appropriations Act of 1995.

Session Laws 1995, c. 507, s. 28.9, provides: "Except for statutory changes or other provisions that clearly indicate an intention to have effects beyond the 1995-97 fiscal biennium, the textual provisions of this act apply only to funds appropriated for, and activities occurring during, the 1995-97 biennium."

§ 58-6-20. Policyholders to furnish information.

Every corporation, firm, or individual doing business in the State shall, upon request of the Commissioner, furnish the Commissioner any information the Commissioner considers necessary to enable the Commissioner to enforce the payment of a tax levied in this Chapter. (1899, c. 54, s. 79; 1901, c. 391, s. 7; 1903, c. 438, s. 8; Rev., s. 4720; C.S., s. 6323; 1987, c. 864, s. 38; 1991, c. 720, s. 4; 1995 (Reg. Sess., 1996), c. 747, s. 11.)

Editor's Note. — Session Laws 1995 (Reg. Sess., 1996), c. 747, s. 16, provides: "This act does not obligate the General Assembly to appropriate funds."

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective January 1, 1997, rewrote this section.

§ 58-6-25. Insurance regulatory charge.

(a) Charge Levied. — There is levied on each insurance company an annual charge for the purposes stated in subsection (d) of this section. As used in this section, the term "insurance company" means a company that pays the gross premiums tax levied in G.S. 105-228.5 and G.S. 105-228.8, except a service corporation subject to Article 65 of this Chapter. A health maintenance organization subject to Article 67 of this Chapter is not subject to those taxes and is therefore not subject to the charge levied in this section. The charge levied in this section is in addition to all other fees and taxes. The charge shall be at a percentage rate of the company's premium tax liability for the taxable year. In determining an insurance company's premium tax liability for a taxable year, additional taxes imposed by G.S. 105-228.8, the additional local fire and lightning tax imposed by G.S. 105-228.5(d)(4), and any tax credits for guaranty or solvency fund assessments under G.S. 105-228.5A or G.S. 97-133(a) shall be disregarded.

(b) Rates. — The rate of the charge for the 1991 taxable year shall be six and five-tenths percent (6.5%). For subsequent taxable years, the rate shall be the percentage rate established by the General Assembly. When the Department prepares its budget request for each upcoming fiscal year, the Department shall propose a percentage rate of the charge levied in this section. The Governor shall submit that proposed rate to the General Assembly each fiscal year. The General Assembly shall set by law the percentage rate of the charge levied in this section. The percentage rate may not exceed the rate necessary to generate funds sufficient to defray the estimated cost of the operations of the Department for each upcoming fiscal year, including a reasonable margin for a reserve fund. The amount of the reserve may not exceed one-third of the estimated cost of operating the Department for each upcoming fiscal year. In calculating the amount of the reserve, the General Assembly shall consider all relevant factors that may affect the cost of operating the Department or a possible unanticipated increase or decrease in North Carolina premiums or other charge revenue.

(c) Returns; When Payable. — The charge levied on each insurance company is payable at the time the insurance company remits its premium tax. If the insurance company is required to remit installment payments of premiums tax under G.S. 105-228.5 for a taxable year, it shall also remit installment payments of the charge levied in this section for that taxable year at the same time and on the same basis as the premium tax installment payments. Each installment payment shall be equal to at least thirty-three and one-third percent (33.3%) of the insurance company's regulatory charge liability incurred in the immediately preceding taxable year.

Every insurance company shall, on or before the date the charge levied in this section is due, file a return on a form prescribed by the Secretary of Revenue. The return shall state the company's total North Carolina premiums for the taxable year and shall be accompanied by any supporting documentation that the Secretary of Revenue may by rule require.

(d) Use of Proceeds. — The Insurance Regulatory Fund is created in the State treasury, under the control of the Office of State Budget and Management. The proceeds of the charge levied in this section and all fees collected under Articles 69 through 71 of this Chapter and under Articles 9 and 9C of Chapter 143 of the General Statutes shall be credited to the Fund. The Fund shall be placed in an interest-bearing account and any interest or other income derived from the Fund shall be credited to the Fund. Moneys in the Fund may be spent only pursuant to appropriation by the General Assembly and in accordance with the line item budget enacted by the General Assembly. The Fund is subject to the provisions of the Executive Budget Act, except that no unexpended surplus of the Fund shall revert to the General Fund. All money credited to the Fund shall be used to reimburse the General Fund for the following:

(1) Money appropriated to the Department of Insurance to pay its expenses incurred in regulating the insurance industry and other industries in this State.

(2) Money appropriated to State agencies to pay the expenses incurred in regulating the insurance industry, in certifying statewide data processors under Article 11A of Chapter 131E of the General Statutes, and in purchasing reports of patient data from statewide data processors certified under that Article.

(3) Money appropriated to the Department of Revenue to pay the expenses incurred in collecting and administering the taxes on insurance companies levied in Article 8B of Chapter 105 of the General Statutes. (1991, c. 689, s. 289; 1991 (Reg. Sess., 1992), c. 812, s. 6(e); 1995, c. 360, ss. 1(i), 3(a); c. 517, s. 39(f), (g); 1995 (Reg. Sess., 1996), c. 646, s. 19; c. 747, s. 3; 1997-443, s. 26.1; 1997-475, s. 2.2.)

Editor's Note. —

Session Laws 1995, c. 178, s. 1(a), effective June 5, 1995, provides: "The percentage rate to be used in calculating the insurance regulatory charge under G.S. 58-6-25 is seven and twenty-five hundredths percent (7.25%) for the 1995 calendar year."

Session Laws 1995, c. 471, s. 6, effective July 1, 1995, provides for the appropriation of funds from the Department of Insurance Fund for the expenses of administering the Department's self-insured workers' compensation program.

Session Laws 1995, c. 517, ss. 39(i) and 41, contain severability clauses.

Session Laws 1995 (Reg. Sess., 1996), c. 670, s. 1(a), provides:

"(a) The percentage rate to be used in calculating the insurance regulatory charge under G.S. 58-6-25 is seven and twenty-five hundredths percent (7.25%) for the 1996 calendar year.

"(b) This section is effective upon ratification [June 21, 1996]."

Session Laws 1995 (Reg. Sess., 1996), c. 747, s. 16, provides: "This act does not obligate the General Assembly to appropriate funds."

Session Laws 1997-443, s. 1.1, provides: "This act shall be known as 'The Current Operations and Capital Improvements Appropriations Act of 1997'".

Session Laws 1997-443, s. 35.4, is a severability clause.

Session Laws 1997-475, s. 2.1, effective September 4, 1997, provides: "The percentage rate to be used in calculating the insurance regulatory charge under G.S. 58-6-25 is eight and seventy-five-hundredths percent (8.75%) for the 1997 calendar year."

Effect of Amendments. — Session Laws 1995, c. 360, s. 1(i), effective January 1, 1996, in the second paragraph of subsection (c) twice substituted "Secretary of Revenue" for "Commissioner" and in the second sentence substituted "The return" for "The report".

Session Laws 1995, c. 360, s. 3(a), effective July 1, 1995, in subsection (a), in the first sentence deleted "to the Department" following "defray the cost" and deleted "and other industries and the general administrative expenses of the State incident thereto" from the end of the sentence; and in subsection (d), in the first sentence substituted "The Insurance Regulatory Fund" for "The Department of Insurance Fund" and added "under the control of the Office of State Budget and Management" to the end of the sentence, and rewrote the last sentence.

Session Laws 1995, c. 517, ss. 39(f) and (g), effective July 29, 1995, substituted "for the purposes stated in subsection (d) of this section" for "to defray the cost of regulating the insurance industry" in subsection (a); and added "in certifying statewide data processors under Article 11A of Chapter 131E of the General Statutes, and in purchasing reports of patient data from statewide data processors certified under that Article" at the end of subsection (d).

Session Laws 1995 (Reg. Sess., 1996), c. 646, s. 19, effective June 21, 1996, in subsection (d), inserted "the following" in the sentence preceding subdivision (d)(1); inserted subdivision (d)(1); and added the subdivision (d)(2) designation and made a related change.

Session Laws 1995 (Reg. Sess., 1996), c. 747, s, 3, effective January 1, 1997, inserted "and the additional local fire and lightning tax imposed by G.S. 105-228.5(d)(4)" preceding "shall be disregarded" in the last sentence of subsection (a).

Session Laws 1997-443, s. 26.1, effective July 1, 1997, added subdivision (d)(3).

Session Laws 1997-475, s. 2.2, effective September 4, 1997, in subsection (a), substituted "a service corporation subject to Article 65 of this Chapter" for "that the term does not include a hospital, medical, or dental service corporation regulated under Articles 65 and 66 of this Chapter" in the second sentence, rewrote the third sentence, and in the last sentence deleted "and" following "G.S. 105-228.8", and substituted "G.S. 105-228.5(d)(4), and any tax credits for guaranty or solvency fund assessments under G.S. 105-228.5A or G.S. 97-133(a)" for "G.S. 105-228.5(d)(4)".

ARTICLE 7.

General Domestic Companies.

§ 58-7-21. Credit allowed a domestic ceding insurer.

(a) As used in this section and in G.S. 58-7-26, 58-7-30, and 58-7-31:

(1) "Reinsurance" means a transfer of insurance risk from a ceding insurer to an assuming insurer.

(2) "Insurance risk" means an uncertainty regarding the ultimate amount of any claim payment (underwriting risk) or an uncertainty regarding the timing of the payments (timing risk), or both.

(b) Credit for reinsurance shall be allowed a domestic ceding insurer as either an asset or a deduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of subdivisions (1), (2), (3), (4), or (5) of this subsection. If meeting the requirements of subdivisions (3) or (4) of this subsection, the reinsurer must also meet the requirements of subdivision (6) of this subsection.

(1) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is licensed to transact insurance or reinsurance in this State.

(2) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is accredited as a reinsurer in this State. An accredited reinsurer is one that:

a. Files with the Commissioner evidence of its submission to this State's jurisdiction;

b. Submits to this State's authority to examine its books and records;

c. Is licensed to transact insurance or reinsurance in at least one state, or in the case of a United States branch of an alien assuming insurer is entered through and licensed to transact insurance or reinsurance in at least one state;

d. Files annually with the Commissioner a copy of its annual statement filed with the insurance regulator of its state of domicile, a copy of its most recent audited financial statement, and a fee of five hundred dollars ($500.00); and either

1. Maintains a policyholders' surplus in an amount that is not less than twenty million dollars ($20,000,000) and whose accreditation has not been denied by the Commissioner within 90 days after its submission; or

2. Maintains a policyholders' surplus in an amount less than twenty million dollars ($20,000,000) and whose accreditation has been approved by the Commissioner.

No credit shall be allowed a domestic ceding insurer if the assuming insurer's accreditation has been revoked by the Commissioner after notice and opportunity for a hearing.

(3) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is domiciled and licensed in, or in the case of a United States branch of an alien assuming insurer is entered through, a state that uses standards regarding credit for reinsurance substantially similar to those applicable under this section and the assuming insurer or United States branch of an alien assuming insurer:

a. Maintains a policyholders' surplus in an amount not less than twenty million dollars ($20,000,000); and

b. Submits to the authority of this State to examine its books and records.

However, the requirement in sub-subdivision (3)a. of this subsection does not apply to reinsurance ceded and assumed under pooling arrangements among insurers in the same holding company system.

(4)a. Credit shall be allowed when the reinsurance is ceded to an assuming insurer that maintains a trust fund in a qualified United States financial institution, as defined in G.S. 58-7-26(b), for the payment of the valid claims of its United States policyholders and ceding insurers, their assigns and successors in interest. The assuming insurer shall report annually to the Commissioner information substantially the same as that required to be reported on the NAIC Annual Statement form by licensed insurers to enable the Commissioner to determine the sufficiency of the trust fund. In the case of a single assuming insurer, the trust shall consist of a trusteed account representing the assuming insurer's liabilities attributable to business written in the United States and, in addition, the assuming insurer shall maintain a trusteed surplus of not less than twenty million dollars ($20,000,000). In the case of a group of insurers, which includes individual unincorporated underwriters, the trust shall consist of a trusteed account representing the group's liabilities attributable to business written in the United States and, in addition, the group shall maintain a trusteed surplus of which one hundred million dollars ($100,000,000) shall be held jointly for the benefit of United States ceding insurers of any member of the group; and the group shall make available to the Commissioner an annual certification of the solvency of each underwriter by the group's domiciliary regulator and its independent certified public accountants.

b. In the case of a group of incorporated insurers under common administration which (i) complies with the filing requirements contained in the previous paragraph, (ii) has continuously transacted an insurance business outside the United States for at least three years immediately before making application for accreditation, (iii) submits to this State's authority to examine its books and records, and (iv) has aggregate policyholders' surplus of ten billion dollars ($10,000,000,000); the trust shall be in an amount equal to the group's several liabilities attributable to business ceded by United States ceding insurers to any member of the group under reinsurance contracts issued in the name of the group. In addition, the group shall maintain a joint trusteed surplus of which one hundred million dollars ($100,000,000) shall be held jointly for the benefit of United States ceding insurers of any member of the group as additional security for any such liabilities, and each member of the group shall make available to the Commissioner an annual certification of the member's solvency by the member's domiciliary regulator and its independent public accountant.

c. The trust shall be established in a form approved by the Commissioner. The trust instrument shall provide that contested claims shall be valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust shall vest legal title to its assets in the trustees of the trust for its United States policyholders and ceding insurers, their assigns and successors in interest. The trust and the assuming insurer shall be subject to examination as determined by the Commissioner. The trust shall remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust.

d. No later than February 28 of each year the trustees of the trust shall report to the Commissioner in writing, setting forth the balance of the trust and listing the trust's investments at the end of the preceding year, and shall certify the date of termination of the trust, if so planned, or certify that the trust shall not expire before the next following December 31.

(5) Credit shall be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of subdivisions (1), (2), (3), or (4) of this subsection, but only with respect to the insurance of risks located in jurisdictions where the reinsurance is required by applicable law or regulation of that jurisdiction.

(6) If the assuming insurer is not licensed or accredited to transact insurance or reinsurance in this State, the credit permitted by subdivisions (3) and (4) of this subsection shall not be allowed unless the assuming insurer agrees in the reinsurance agreements:

a. That if the assuming insurer fails to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the ceding insurer's request, shall submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, shall comply with all requirements necessary to give the court jurisdiction, and shall abide by the final decision of the court or of any appellate court if there is an appeal; and

b. To designate the Commissioner as its true and lawful attorney upon whom may be served any lawful process in any action, suit, or proceeding begun by or on behalf of the ceding company.

This subdivision does not affect the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if such an obligation is created in the agreement.

(c) This section applies to all reinsurance cessions made on or after January 1, 1992, under reinsurance agreements that have an inception, anniversary, or renewal date on or after January 1, 1992. (1991, c. 681, s. 22; 1993, c. 452, s. 42; 1993 (Reg. Sess., 1994), c. 678, s. 8; 1995, c. 193, s. 13; c. 360, s. 2(g).)

Editor's Note. —
Session Laws 1995, c. 193, s. 67, contains a severability clause.

§ 58-7-30. Insolvency of ceding insurer; exceptions; written reinsurance agreements.

(a) Notwithstanding any other provision of this Article, no credit shall be allowed, as an admitted asset or as a deduction from liability, to any ceding insurer for reinsurance, unless the reinsurance is payable by the assuming insurer, on the basis of claims allowed against the ceding insurer under the contract or contracts reinsured without diminution because of the insolvency of the ceding insurer, directly to the ceding insurer or to its domiciliary receiver except (1) where the contract specifically provides for another payee of the reinsurance in the event of the insolvency of the ceding insurer or (2) where the assuming insurer, with the consent of the direct insured or insureds, has assumed the policy obligations of the ceding insurer as direct obligations of the assuming insurer to the payees under the policies and in substitution of the obligations of the ceding insurer to the payees.

(b) No credit shall be allowed, as an admitted asset or as a deduction from liability, to any ceding insurer for reinsurance, unless the reinsurance is documented by a policy, certificate, treaty, or other form of agreement that is properly executed by an authorized officer of the assuming insurer. If the reinsurance is ceded through an underwriting manager or agent, the manager or agent shall provide to the domestic ceding insurer evidence of the manager or agent's authority to assume reinsurance for and on behalf of the assuming insurer. The evidence shall consist of either an acceptable letter of authority executed by an authorized officer of the assuming insurer or a copy of the actual agency agreement between the underwriting manager or agent and the assuming insurer; and the evidence shall be specific as to the classes of business within the authority and as to the term of the authority. If there is any conflict between this subsection and Article 9 of this Chapter, the provisions of Article 9 govern. (1985, c. 572, s. 1; 1995, c. 193, s. 14; c. 517, s. 4.)

Editor's Note. — Session Laws 1995, c. 193, s. 13 and c. 517, s. 41, contain severability clauses.

Effect of Amendments. — Session Laws 1995, c. 193, s. 13, effective June 7, 1995, added "Notwithstanding any other provision of this Article" to the beginning of the section.

Session Laws 1995, c. 517, s. 4, effective October 1, 1995, added "written reinsurance agreements" in the catchline; added the subsection (a) designation; and added subsection (b).

§ 58-7-31. Life and health reinsurance agreements.

(a) Notwithstanding any other provision of this Article, this section applies to every domestic life and accident and health insurer, to every other licensed life and accident and health insurer that is not subject to a substantially similar statute or administrative rule in its domiciliary state, and to every licensed property and casualty insurer with respect to its accident and health business. This section does not apply to assumption reinsurance, yearly renewable term reinsurance, nor to certain nonproportional reinsurance, such as stop loss or catastrophe reinsurance.

(b) No insurer shall, for reinsurance ceded, reduce any liability or establish any asset in any financial statement filed with the Commissioner if, by the terms of the reinsurance agreement, in substance or effect, any of the following conditions exist:

(1) Renewal expense allowances provided or to be provided to the ceding insurer by the reinsurer in any accounting period, are not sufficient to cover anticipated allocable renewal expenses of the ceding insurer on the portion of the business reinsured, unless a liability is established for the present value of the shortfall, using assumptions equal to the applicable statutory reserve basis on the business reinsured. Those expenses include commissions, premium taxes, and direct expenses including, but not limited to, billing, valuation, claims, and maintenance expected by the company at the time the business is reinsured.

(2) The ceding insurer can be deprived of surplus or assets at the reinsurer's option or automatically upon the occurrence of some event, such as the insolvency of the ceding insurer; except that termination of the reinsurance agreement by the reinsurer for nonpayment of reinsurance premiums or other amounts due, such as modified coinsurance reserve adjustments, interest, and adjustments on funds withheld, and tax reimbursements, are not a deprivation of surplus or assets.

(3) The ceding insurer is required to reimburse the reinsurer for negative experience under the reinsurance agreement; except that neither offsetting experience refunds against current and prior years' losses under the reinsurance agreement nor payment by the ceding insurer of an amount equal to the current and prior years' losses under the reinsurance agreement upon voluntary termination of in-force reinsurance by the ceding insurer are a reimbursement to the reinsurer for negative experience. Voluntary termination does not include situations where termination occurs because of unreasonable provisions that allow the reinsurer to reduce its risk under the reinsurance agreement.

(4) The ceding insurer must, at specific points in time scheduled in the reinsurance agreement, terminate or automatically recapture all or part of the reinsurance ceded.

(5) The reinsurance agreement involves the possible payment by the ceding insurer to the reinsurer of amounts other than from income realized from the reinsured policies. No ceding company shall pay reinsurance premiums or other fees or charges to a reinsurer that are greater than the direct premiums collected by the ceding company.

(6) The treaty does not transfer all of the significant risk inherent in the business being reinsured. The following table identifies for a representative sampling of products or type of business, the risks that are considered to be significant. For products not specifically included, the risks determined to be significant shall be consistent with this table.

Risk Categories:

a.= Morbidity.

b.= Mortality.

Risk Categories:

c.= Lapse. (This is the risk that a policy will voluntarily terminate before the recoupment of a statutory surplus strain experienced at issue of the policy.)

d.= Credit Quality (C1). (This is the risk that invested assets supporting the reinsured business will decrease in value. The main hazards are that assets will default or that there will be a decrease in earning power. It excludes market value declines due to changes in interest rate.)

e.= Reinvestment (C3). (This is the risk that interest rates will fall and funds reinvested [coupon payments or monies received upon asset maturity or call] will therefore earn less than expected. If asset durations are less than liability durations, the mismatch will increase.)

f.= Disintermediation (C3). (This is the risk that interest rates will rise and policy loans and surrenders increase or maturing contracts do not renew at anticipated rates of renewal. If asset durations are greater than the liability durations, the mismatch will increase. Policyholders will move their funds into new products offering higher rates. The company may have to sell assets at a loss to provide for these withdrawals.)

+= Significant 0 = Insignificant

RISK CATEGORY

	a	b	c	d	e	f
Health Insurance — other than LTC/LTD*	+	0	+	0	0	0
Health Insurance — LTC/LTD*	+	0	+	+	+	0
Immediate Annuities	0	+	0	+	+	0
Single Premium Deferred Annuities	0	0	+	+	+	+
Flexible Premium Deferred Annuities	0	0	+	+	+	+
Guaranteed Interest Contracts	0	0	0	+	+	+
Other Annuity Deposit Business	0	0	+	+	+	+
Single Premium Whole Life	0	+	+	+	+	+
Traditional Non-Par Permanent	0	+	+	+	+	+
Traditional Non-Par Term	0	+	+	0	0	0
Traditional Par Permanent	0	+	+	+	+	+
Traditional Par Term	0	+	+	0	0	0
Adjustable Premium Permanent	0	+	+	+	+	+
Indeterminate Premium Permanent	0	+	+	+	+	+
Universal Life Flexible Premium	0	+	+	+	+	+
Universal Life Fixed Premium	0	+	+	+	+	+
Universal Life Fixed Premium (dump-in premiums allowed)	0	+	+	+	+	+

*LTC = Long-Term Care Insurance

*LTD = Long-Term Disability Insurance

(7)a. The credit quality, reinvestment, or disintermediation risk is significant for the business reinsured and the ceding company does not (other than for the classes of business excepted in subdivision (7)b. of this section) either transfer the underlying assets to the reinsurer or legally segregate such assets in a trust or escrow account or otherwise establish a mechanism satisfactory to the Commissioner that legally segregates, by contract or contractual provisions, the underlying assets.

b. Notwithstanding the requirements of subdivision (7)a. of this section, the assets supporting the reserves for the following classes of business and any classes of business that do not have a significant credit quality, reinvestment, or disintermediation risk may be held by the ceding company without segregation of those assets:

— Health Insurance — LTC/LTD
— Traditional Non-Par Permanent
— Traditional Par Permanent
— Adjustable Premium Permanent
— Indeterminate Premium Permanent
— Universal Life Fixed Premium
(no dump-in premiums allowed)

The associated formula for determining the reserve interest rate adjustment must use a formula that reflects the ceding company's investment earnings and incorporates all realized and unrealized gains and losses reflected in the statutory statement. The following is an acceptable formula:

$$\text{Rate} = \frac{2\,(I + CG)}{X + Y - I - CG}$$

Where: I is the net investment income.
CG is capital gains less capital losses.
X is the current year cash and invested assets plus investment income due and accrued less borrowed money.
Y is the same as X but for the prior year.

(8) Settlements are made less frequently than quarterly or payments due from the reinsurer are not made in cash within 90 days after the settlement date.

(9) The ceding insurer is required to make representations or warranties not reasonably related to the business being reinsured.

(10) The ceding insurer is required to make representations or warranties about future performance of the business being reinsured.

(11) The reinsurance agreement is entered into for the principal purpose of producing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business reinsured and, in substance or effect, the expected potential liability to the ceding insurer remains basically unchanged.

(c) Notwithstanding subsection (a) of this section, an insurer may, with the prior approval of the Commissioner, take such reserve credit or establish such asset as the Commissioner deems to be consistent with the insurance laws or rules of this State, including actuarial interpretations or standards adopted by the Commissioner.

(d)(1) Reinsurance agreements entered into after October 1, 1993, that involve the reinsurance of business issued prior to the effective date of the reinsurance agreements, along with any subsequent amendments thereto, shall be filed by the ceding company with the Commissioner within 30 days after its date of execution. Each filing shall include data detailing the final impact of the transaction. The ceding insurer's actuary who signs the financial statement actuarial opinion with respect to valuation of reserves shall consider this statute and any applicable actuarial standards of practice when determining the proper credit in financial statements filed with the Commissioner. The actuary should maintain adequate documentation and be prepared upon request to describe the actuarial work performed for inclusion in the financial statements and to demonstrate that such work conforms to this statute.

(2) Any increase in surplus net of federal income tax resulting from arrangements described in subdivision (d)(1) of this section shall be identified separately on the insurer's statutory financial statement as a surplus item (aggregate write-ins for gains and losses in surplus in the Capital and Surplus Account, page 4 of the Annual Statement) and recognition of the surplus increase as income shall be reflected on a net of tax basis in the "Reinsurance Ceded" line, page 4 of the Annual Statement as earnings emerge from the business reinsured.

(e) No reinsurance agreement or amendment to any reinsurance agreement may be used to reduce any liability or to establish any asset in any financial statement filed with the Commissioner, unless the reinsurance agreement, amendment, or a binding letter of intent has been duly executed by both parties no later than the "as of date" of the financial statement.

(f) In the case of a letter of intent, a reinsurance agreement or an amendment to a reinsurance agreement must be executed within a reasonable period of time, not exceeding 90 days after the execution date of the letter of intent, in order for credit to be granted for the reinsurance ceded.

(g) The reinsurance agreement shall contain provisions that provide that:

(1) The reinsurance agreement shall constitute the entire reinsurance agreement between the parties with respect to the business being reinsured thereunder and that there are no understandings between the parties other than as expressed in the reinsurance agreement; and

(2) Any change or modification to the reinsurance agreement shall be null and void unless made by amendment to the reinsurance agreement and signed by both parties.

(h) Insurers subject to this section shall reduce to zero by December 31, 1994, any reserve credits or assets established with respect to reinsurance agreements entered into prior to October 1, 1993, that, under the provisions of this section, would not be entitled to recognition of such reserve credits or assets; provided, however, that such reinsurance agreements shall have been in compliance with laws or regulations in existence immediately preceding October 1, 1993. (1993, c. 452, s. 4; 1993 (Reg. Sess., 1994), c. 678, s. 9; 1995, c. 193, ss. 15, 16.)

Editor's Note. —
Session Laws 1995, c. 193, s. 67, contains a severability clause.

§ 58-7-75. Amount of capital and/or surplus required; impairment of capital or surplus.

The amount of capital and/or surplus requisite to the formation and organization of companies under the provisions of Articles 1 through 64 of this Chapter shall be as follows:

(1) Stock Life Insurance Companies. — A stock corporation may be organized in the manner prescribed in this Chapter and licensed to do the business of life insurance, only when it has paid-in capital of at least six hundred thousand dollars ($600,000) and a paid-in initial surplus of at least nine hundred thousand dollars ($900,000), and it may in addition do the kind of business specified in G.S. 58-7-15(2), without having additional capital or surplus. Every such company shall at all times thereafter maintain a minimum capital of not less than six hundred thousand dollars ($600,000) and a minimum surplus of at least one hundred fifty thousand dollars ($150,000). Provided that, any such corporation may do either or both of the kinds of insurance authorized for stock accident and health insurance companies, as set out in G.S. 58-7-15(3)a. and b., where its charter so permits, and only as long as it maintains a minimum capital and surplus equal to the sum of the minimum capital and surplus requirements of this subdivision and the minimum capital and surplus requirements of subdivision (2) of this section.

(2) Stock Accident and Health Insurance Companies.

a. A stock corporation may be organized in the manner prescribed in this Chapter and licensed to do only the kind of insurance specified in G.S. 58-7-15(3)a, when it has paid-in capital of not less than four hundred thousand dollars ($400,000), and a paid-in initial surplus of at least six hundred thousand dollars ($600,000). Every such company shall at all times thereafter maintain a minimum capital of not less than four hundred thousand dollars ($400,000) and a minimum surplus of at least one hundred thousand dollars ($100,000).

b. Any company organized under the provisions of paragraph a of this subdivision may, by the provisions of its original charter or any amendment thereto, acquire the power to do the kind of business specified in G.S. 58-7-15(3)b, if it has a paid-in capital of at least six hundred thousand dollars ($600,000) and a paid-in initial surplus of at least nine hundred thousand dollars ($900,000). Every such company shall at all times maintain a minimum capital of not less than six hundred thousand dollars ($600,000) and a minimum surplus of at least one hundred fifty thousand dollars ($150,000).

(3) Stock Fire and Marine Companies. — A stock corporation may be organized in the manner prescribed in this Chapter and licensed to do one or more of the kinds of insurance specified in G.S. 58-7-15 (4), (5), (6), (7), (8), (11), (12), (19), (20), (21) and (22) only when it has a paid-in capital of not less than eight hundred thousand dollars ($800,000) and a paid-in initial surplus of not less than one million two hundred thousand dollars ($1,200,000). Every such company shall at all times thereafter maintain a minimum capital of not less than eight hundred thousand dollars ($800,000) and a minimum surplus of at least two hundred thousand dollars ($200,000). Provided that, any such corporation may do all the kinds of insurance authorized for casualty, fidelity and surety companies, as set out in subdivision (4) of this section where its charter so permits, and when and so long as it meets and thereafter maintains a minimum capital and surplus equal to the sum of the minimum capital and surplus requirements of this subdivision and the minimum capital and surplus requirements of subdivision (4) of this section.

(4) Stock Casualty and Fidelity and Surety Companies. — A stock corporation may be organized in the manner prescribed in this Chapter and licensed to do one or more of the kinds of insurance specified in G.S. 58-7-15 (3), (6), (7), (8), (9), (10), (11), (12), (13), (14), (15), (16), (17), (18), (19), (21) and (22) only when it has a paid-in capital of not less than one million dollars ($1,000,000) and a paid-in initial surplus of not less than one million five hundred thousand dollars ($1,500,000). Every such company shall at all times thereafter maintain a minimum capital of not less than one million dollars ($1,000,000) and a minimum surplus of at least two hundred fifty thousand dollars ($250,000).

(5) Mutual Fire and Marine Companies.

a. Limited assessment companies. — A limited assessment mutual company may be organized in the manner prescribed in this Chapter and licensed to do one or more kinds of insurance specified in G.S. 58-7-15 (4), (5), (6), (7), (8), (11), (12), (19), (20), (21) and (22) only when it has no less than five hundred thousand dollars ($500,000) of insurance in not fewer than 500 separate risks subscribed with a paid-in initial surplus of at least three hundred thousand dollars ($300,000), which surplus shall at all times be maintained. The assessment liability of a policyholder of a company organized in accordance with the provisions of this sub-subdivision shall not be limited to less than five annual premiums; provided, the limited assessment company may reduce the assessment liability of its policyholders from such five annual premiums to one additional annual premium when the free surplus of the company amounts to not less than three hundred thousand dollars ($300,000), which surplus shall at all times be maintained.

b. Assessable mutual companies. — An assessable mutual company may be organized in the manner prescribed in this Chapter and licensed to do one or more of the kinds of insurance specified in G.S. 58-7-15 (4), (5) and (6), with an unlimited assessment liability of its policyholders only when it has not less than five hundred thousand dollars ($500,000) of insurance in not fewer than 500 separate risks subscribed with a paid-in initial surplus equal to twice the amount of the maximum net retained liability under the largest policy of insurance issued by the company; but not less than sixty thousand dollars ($60,000); which surplus shall at all times be maintained. Provided the company, when its charter so permits, in addition may be licensed to do one or more of the kinds of insurance specified in G.S. 58-7-15 (7), (8), (11), (12), (19), (20), (21) and (22), with an unlimited assessment liability of its policyholders, when its free surplus amounts to not less than sixty thousand dollars ($60,000), which surplus shall at all times be maintained.

c. Nonassessable mutual companies. — A nonassessable mutual company may be organized in the manner prescribed in this Chapter and licensed to do one or more of the kinds of insurance specified in G.S. 58-7-15 (4), (5), (6), (7), (8), (11), (12), (19), (20), (21) and (22) and may be authorized to issue policies under the terms of which a policyholder is not liable for any assessments in addition to the premium set out in the policy only when it has not less than five hundred thousand dollars ($500,000) of insurance in not fewer than 500 separate risks subscribed with a paid-in initial surplus of not less than eight hundred thousand dollars ($800,000), which surplus shall at all times be maintained.

d. Town or county mutual insurance companies. — A town or county mutual insurance company with unlimited assessment liability may be organized in the manner prescribed in this Chapter and licensed to do the kinds of insurance specified in G.S. 58-7-15(4) only when it has not less than fifty thousand dollars ($50,000) of insurance in force in not fewer than 50 separate risks subscribed with a paid-in initial surplus of not less than fifteen thousand dollars ($15,000), which surplus shall at all times be maintained. A town or county mutual insurance company may, in addition to writing the business specified in G.S. 58-7-15(4) cover in the same policy the hazards usually insured against under an extended coverage endorsement when the company has not less than five hundred thousand dollars ($500,000) of insurance in force in not fewer than 500 separate risks and maintains a surplus at all times of not less than one hundred twenty thousand dollars ($120,000): Provided, that the company may not operate in more than six adjacent counties in this State. Any company authorized under this section before July 1, 1991, shall be permitted to continue to do the same kinds of business that it was authorized to do prior to July 1, 1991, without being required to increase its surplus; however, the insurer shall increase its surplus to the required amounts on or before July 1, 1992. The requirements of this sub-subdivision as to surplus shall apply to such companies as a prerequisite to writing additional lines of business, and to such companies as a prerequisite to commencing business if unlicensed prior to July 1, 1991.

(6) Mutual Life, Accident and Health Insurance Companies. — A nonassessable mutual insurance company may be organized in the manner prescribed in this Chapter, and licensed to do only one or more of the kinds of insurance specified in G.S. 58-7-15 (1), (2) and (3) when it has complied with the requirements of this Chapter and with those set forth in sub-subdivisions a through d of this subdivision, inclusive, whichever shall be applicable.

a. If organized to do only the kinds of insurance specified in G.S. 58-7-15 (1) and (2) the company shall have not less than 500 bona fide applications for life insurance in an aggregate amount not less than five hundred thousand dollars ($500,000), and shall have received from each such applicant in cash the full amount of one annual premium on the policy for which the applicant applied, in an aggregate amount at least equal to ten thousand dollars ($10,000), and shall in addition have a paid-in initial surplus of two hundred thousand dollars ($200,000), and shall have and maintain at all times a minimum surplus of one hundred thousand dollars ($100,000).

b. If organized to do only the kind of insurance specified in paragraph a of G.S. 58-7-15(3) the company shall have not less than 250 bona fide applications for that insurance, and shall have received from each applicant in cash the full amount of one annual premium on the policy for which the applicant applied, in an aggregate amount of at least ten thousand dollars ($10,000), and shall have a paid-in initial surplus of two hundred thousand dollars ($200,000) and shall have and maintain at all times a minimum surplus of one hundred thousand dollars ($100,000).

c. If organized to do the kinds of insurance specified in G.S. 58-7-15 (1) and (3)a, the company shall have complied with the provisions of sub-subdivisions a and b of this subdivision.

d. If organized to do the kind of insurance specified in G.S. 58-7-15(3)b, in addition to the kind or kinds of insurance designated in any one of the preceding sub-subdivisions of this subdivision, the company shall have a paid-in initial surplus of at least five hundred thousand dollars ($500,000) and shall maintain a minimum surplus of at least three hundred thousand dollars ($300,000).

(7) Organization of Mutual Casualty, Fidelity and Surety Companies.

a. Nonassessable, mutual companies. — A mutual insurance company with no assessment liability provided for its policyholders may be organized in the manner prescribed in this Chapter and licensed to do one or more of the kinds of insurance specified in G.S. 58-7-15 (3), (6), (7), (8), (9), (10), (11), (12), (13), (14), (15), (16), (17), (18), (19), (21) and (22) when it has a minimum paid-in initial surplus of one million dollars ($1,000,000) and not less than five hundred thousand dollars ($500,000) in insurance subscribed in not less than 500 separate risks. The surplus of the company shall at all times be maintained at or above that amount.

b. Assessable mutual companies. — A mutual insurance company with assessment liability provided for its policyholders may be organized in the manner prescribed in this Chapter and licensed to do one or more of the kinds of insurance specified in G.S. 58-7-15 (3), (6), (7), (8), (9), (10), (11), (12), (13), (14), (15), (16), (17), (18), (19), (21) and (22) when it has a minimum paid-in initial surplus of four hundred thousand dollars ($400,000) and not less than five hundred thousand dollars ($500,000) of insurance subscribed in not less than 500 separate risks. The company shall at all times maintain a surplus in an amount not less than four hundred thousand dollars ($400,000). The assessment liability of a policyholder of the company shall not be limited to less than one annual premium.

(8) Organization of Mutual Multiple Line Companies.

a. Assessable mutual companies. — A company may do all the kinds of insurance authorized to be done by a company organized under the provisions of sub-subdivision (5)a, and sub-subdivision (7)b of this subdivision, where its charter so permits when and if it meets the combined minimum requirements of those sub-subdivisions. The assessment liability of policyholders of such a company shall not be limited to less than one annual premium within any one policy year.

b. Nonassessable mutual companies. — A company may do all the kinds of insurance authorized to be done by a company organized under the provisions of sub-subdivision (5)c, and sub-subdivision (7)a of this subdivision, where its charter so permits when and if it meets the combined minimum requirements of those paragraphs. The policyholders of such a company shall not be subject to any assessment liability.

(9) Repealed by Session Laws 1991, c. 644, s. 32, effective July 12, 1991.

(10) Impairment of Capital and/or Surplus. — Whenever the Commissioner finds from a financial statement made by any company, or from a report of examination of any company, that its admitted assets are less than the aggregate amount of its liabilities and its outstanding capital stock and/or required minimum surplus, the Commissioner shall determine the amount of the impairment of capital and/or surplus and issue an order in writing requiring the company to eliminate the impairment within such period of not more than 90 days as the Commissioner shall desig-

nate. The Commissioner may, by order served upon the company, prohibit the company from issuing any new policies while the impairment exists. If at the expiration of the designated period the company has not satisfied the Commissioner that the impairment has been eliminated, an order for the rehabilitation or liquidation of the company may be entered as provided in Article 30 of this Chapter.

(11) The Commissioner may require an insurer to have and maintain a larger amount of capital or surplus than prescribed in this section, based upon the volume and kinds of insurance transacted by the insurer and on the principles of risk-based capital as determined by the NAIC or the Commissioner. (1899, c. 54, s. 26; 1903, c. 438, s. 4; Rev., s. 4729; 1907, c. 1000, s. 5; 1913, c. 140, s. 2; C.S., s. 6332; 1929, c. 284, s. 1; 1945, c. 386; 1947, c. 721; 1963, c. 943; 1965, c. 947; 1967, c. 300; 1971, c. 536; 1973, c. 686; 1979, c. 421, s. 1; 1983, c. 472; 1985, c. 666, s. 75; 1985 (Reg. Sess., 1986), c. 1013, s. 10; 1989, c. 485, s. 53; 1991, c. 644, s. 32; c. 681, s. 27; 1995, c. 193, s. 17.)

Editor's Note. — Session Laws 1995, c. 193, s. 67, contains a severability clause.

§ 58-7-150. Consolidation.

(a) A domestic insurer may consolidate with another insurer, subject to the following conditions:

(1) The plan of consolidation must be submitted to and be approved by the Commissioner in advance of the consolidation.

(2) The Commissioner shall not approve any such plan unless, after a hearing, he finds that it is fair, equitable to policyholders, consistent with law, and will not conflict with the public interest. If the Commissioner fails to approve the plan, he shall state his reasons for such failure in his order made on such hearing.

(3) No director, officer, member or subscriber of any such insurer, except as is expressly provided by the plan of consolidation, shall receive any fee, commission, other compensation or valuable consideration whatever, for in any manner aiding, promoting or assisting in the consolidation.

(4) Any consolidation as to an incorporated domestic insurer shall in other respects be governed by the general laws of this State relating to business corporations, except that the consolidation of a domestic mutual insurer may be effected by vote of two thirds of the members voting thereon pursuant to such notice and procedure as the Commissioner may prescribe.

(b) Reinsurance of all or substantially all of the insurance in force of a domestic insurer by another insurer under an agreement whereby the reinsuring company succeeds to all of the liabilities of and supplants the domestic insurance company thereon shall be deemed a consolidation for the purposes of this section.

(c) An application for consolidation under this section shall be accompanied by a nonrefundable fee of two hundred fifty dollars

($250.00). (1947, c. 923; 1955, c. 905; 1985, c. 572, s. 4; 1989 (Reg. Sess., 1990), c. 1069, s. 10; 1993, c. 452, s. 7; 1993 (Reg. Sess., 1994), c. 678, s. 10; 1995, c. 193, s. 18.)

Editor's Note. —

Session Laws 1995, c. 507, s. 1.1, provides that this act shall be known and cited as the Expansion and Capital Improvements Appropriations Act of 1995.

Session Laws 1995, c. 507, s. 28.9, provides: "Except for statutory changes or other provisions that clearly indicate an intention to have effects beyond the 1995-97 fiscal biennium, the textual provisions of this act apply only to funds appropriated for, and activities occurring during, the 1995-97 biennium."

Session Laws 1995, c. 507, s. 11A(c), amended Session Laws 1989 (Reg. Sess., 1990), c. 1069, s. 31, deleting the last sentence regarding the expiration of amendments to the General Statutes by Session Laws 1989 (Reg. Sess., 1990), c. 1069, if the legislature did not appropriate or transfer funds. Session Laws 1989 (Reg. Sess., 1990), c. 1069, s. 31, as amended by Session Laws 1995, c. 507, s. 11A(c), provides: "Section 23 [see § 58-36-70] of this act does not apply to the 1990 automobile rate filing made pursuant to Article 36 of Chapter 58 of the General Statutes. Section 27 [§ 143-3.6] of this act shall expire at the end of the 1993-1994 fiscal year and Section 28 [§ 143-3.7] shall become effective upon the expiration of Section 27."

Session Laws 1995, c. 193, s. 67, contains a severability clause.

§ 58-7-155. Application fee.

Editor's Note. —

Session Laws 1995, c. 507, s. 1.1, provides that this act shall be known and cited as the Expansion and Capital Improvements Appropriations Act of 1995.

Session Laws 1995, c. 507, s. 28.9, provides: "Except for statutory changes or other provisions that clearly indicate an intention to have effects beyond the 1995-97 fiscal biennium, the textual provisions of this act apply only to funds appropriated for, and activities occurring during, the 1995-97 biennium."

Session Laws 1995, c. 507, s. 11A(c), amended Session Laws 1989 (Reg. Sess., 1990), c. 1069, s. 31, deleting the last sentence regarding the expiration of amendments to the General Statutes by Session Laws 1989 (Reg. Sess., 1990), c. 1069, if the legislature did not appropriate or transfer funds. Session Laws 1989 (Reg. Sess., 1990), s. 31, as amended by Session Laws 1995, c. 507, s. 11A(c), provides: "Section 23 [see § 58-36-70] of this act does not apply to the 1990 automobile rate filing made pursuant to Article 36 of Chapter 58 of the General Statutes. Section 27 [§ 143-3.6] of this act shall expire at the end of the 1993-1994 fiscal year and Section 28 [§ 143-3.7] shall become effective upon the expiration of Section 27."

§ 58-7-162. Allowable or admitted assets.

In any determination of the financial condition of an insurer, there shall be allowed as assets only those assets owned by an insurer and that consist of:

(1) Cash in the possession of the insurer, or in transit under its control, and including the true balance of any deposit in a solvent United States bank, savings and loan association, or trust company, and the balance of any such deposit in an insolvent United States bank, savings and loan association, or trust company, to the extent insured by a federal agency.

(2) Investments, securities, properties, and loans acquired or held in accordance with this Chapter, and in connection therewith the following items:

a. Interest due or accrued on any bond or evidence of indebtedness that is not in default.

b. Declared and unpaid dividends on stock and shares, unless that amount has otherwise been allowed as an asset.

c. Interest due or accrued upon a collateral loan in an amount not to exceed one year's interest thereon.

d. Interest due or accrued on deposits in solvent banks, savings and loan associations, and trust companies, and interest due or accrued on other assets, if the interest is, in the Commissioner's judgment, a collectible asset.

e. Interest due or accrued on a current mortgage loan, in an amount not exceeding in any event the amount, if any, of the excess of the value of the property less delinquent taxes thereon over the unpaid principal; but in no event shall interest accrued for a period in excess of 90 days be allowed as an asset.

f. Rent due or accrued on real property if the rent is not in arrears for more than three months, and rent more than three months in arrears if the payment of the rent is adequately secured by property held in the tenant's name and conveyed to the insurer as collateral and the underlying collateral is admissible under this Chapter.

g. The unaccrued portion of taxes paid before the due date on real property.

(3) Premium notes, policy loans, and other policy assets and liens on policies and certificates of life insurance and annuity contracts and accrued interest thereon, in an amount not exceeding the legal reserve and other policy liabilities carried on each individual policy.

(4) The net amount of uncollected and deferred premiums and annuity considerations in the case of a life insurer.

(5) Premiums in the course of collection, other than for nonsingle premium life insurance, not more than 90 days past due, less commissions payable thereon, except for premiums payable directly or indirectly by the United States government or by any of its instrumentalities.

(6) All premiums in the course of collection not more than 90 days past due, excluding commissions payable thereon, due from any person that solely or in combination with the person's affiliates owes the insurer an amount that equals or exceeds five percent (5%) of the insurer's surplus as regards policyholders, but only if:

a. The premiums collected by the person or affiliates and not remitted to the insurer are held in a trust account with a bank or other depository approved by the Commissioner. The funds shall be held as trust funds and may not be commingled with any other funds of the person or affiliates. Disbursements from the trust account may be made only to the insurer, the insured, or, for the purpose of returning premiums, a person that is entitled to returned premiums on behalf of the insured. A written copy of the trust agreement shall be filed with and approved by the Commissioner before becoming effective. The Commissioner shall disapprove any trust agreement filed under this sub-subdivision that does not assure the safety of the premiums collected. The investment income derived from the trust may be allocated as the parties consider to be proper. The person or affiliates shall deposit premiums collected into the trust account within 15 business days after collection; or

b. The person or affiliates shall provide to the insurer, and the insurer shall maintain in its possession, an unexpired, clean, irrevocable letter of credit, payable to the insurer, issued for a term of no less than one year and in conformity with the requirements set forth in this sub-subdivision, the amount of which equals or exceeds the liability of the person or affiliates to the insurer, at all times during the period that the letter of credit is in effect, for premiums collected by the person or affiliates. The letter of credit shall be issued under arrangements satisfactory to the Commissioner and the letter shall be issued by a banking institution that is a member of the Federal Reserve System and that has a financial standing satisfactory to the Commissioner; or

c. The person or affiliates shall provide to the insurer, and the insurer shall maintain in its possession, evidence that the person or affiliates have purchased and have currently in effect a financial guaranty bond, payable to the insurer, issued for a term of not less than one year and that is in conformity with the requirements set forth in this sub-subdivision, the amount of which equals or exceeds the liability of the person or affiliates to the insurer, at all times during which the financial guaranty bond is in effect, for the premiums collected by the person or persons. The financial guaranty bond shall be issued under an arrangement satisfactory to the Commissioner and the financial guaranty bond shall be issued by an insurer that is authorized to transact that business in this State, that has a financial standing satisfactory to the Commissioner, and that is neither controlled nor controlling in relation to either the insurer or the person or affiliates for whom the bond is purchased.

Premiums receivable under this subdivision will not be allowed as an admitted asset if a financial evaluation by the Commissioner indicates that the person or affiliates are unlikely to be able to pay the premiums as they become due. The financial evaluation shall be based on a review of the books and records of the controlling or controlled person.

(7) Installment premiums other than life insurance premiums to the extent of the unearned premium reserve carried on the policy to which the premiums apply.

(8) Notes and like written obligations not past due, taken for premiums other than life insurance premiums, on policies permitted to be issued on that basis, to the extent of the unearned premium reserves carried thereon.

(9) The full amount of reinsurance which is recoverable by a ceding insurer from a solvent reinsurer and is authorized under G.S. 58-7-21.

(10) Amounts receivable by an assuming insurer representing funds withheld by a solvent ceding insurer under a reinsurance treaty.

(11) Deposits or equities recoverable from underwriting associations, syndicates, and reinsurance funds, or from any suspended banking institution, to the extent considered by the Commissioner to be available for the payment of losses and claims and at values to be determined by the Commissioner.

(12) Electronic and mechanical machines, including operating and system software constituting a management information system, if the cost of the system is at least twenty-five thousand dollars ($25,000) but not more than two percent (2%) of total admitted assets; the cost shall be amortized in full over a period not to exceed seven calendar years.

(13) Other assets, not inconsistent with the provisions of this section, considered by the Commissioner to be available for the payment of losses and claims, at values to be determined by the Commissioner. (1991, c. 681, s. 29; 1993, c. 452, s. 8; 1995 (Reg. Sess., 1996), c. 659, s. 1.)

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective October 1, 1996, in the introductory language of subdivision (6), inserted "in the course of collection" following "All premiums", inserted "equals or" following "the insurer an amount that", and substituted "surplus as regards policyholders" for "total premiums in course of collection."

§ 58-7-177. Investments in subsidiaries and affiliated corporations.

(a) Any insurer, either by itself or in cooperation with one or more persons, may organize or acquire one or more subsidiaries, subject to the limitations of this Chapter. The subsidiaries may conduct any kind of business, and their authority to do so shall not be limited because they are subsidiaries of an insurer, except where in conflict with Article 19 of this Chapter.

(b) In addition to investments in common stock, preferred stock, debt obligations, and other securities permitted under this Chapter, an insurer may also invest and maintain investments in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries under the provisions and limitations outlined in G.S. 58-19-10.

(c) As used in this section "subsidiary" has the same meaning as in G.S. 58-19-5(7).

(d) Debt obligations, other than mortgage loans, made under the authority of this section must meet amortization requirements in accordance with the latest edition of the NAIC publication entitled "Valuation of Securities"; provided that the amortization methodology is acceptable to the Commissioner.

(e) For purposes of this section, an insurer's investment in a subsidiary shall be considered to include all sums lent to the subsidiary. (1991, c. 681, s. 29; 1995, c. 193, s. 19.)

Editor's Note. — Session Laws 1995, c. 193, s. 67, contains a severability clause.

Article 8.

Mutual Insurance Companies.

§ 58-8-1. Mutual insurance companies organized; requisites for doing business.

CASE NOTES

Cited in Warren v. Jackson, 125 N.C. App. 96, 479 S.E.2d 278 (1997).

Article 9.

Reinsurance Intermediaries.

§ 58-9-2. Reinsurance intermediaries.

(a) As used in this Article:

- (1) "Actuary" means a person who meets the standards of a qualified actuary, as specified in the NAIC Annual Statement Instructions, as amended or clarified by rule or order of the Commissioner, for the type of insurer for which an intermediary is establishing loss reserves.
- (2) "Broker" means any person, other than an officer or employee of a ceding insurer, who solicits, negotiates, or places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power to bind reinsurance on behalf of the ceding insurer.
- (3) "Commissioner" includes the Commissioner's authorized deputies and employees.
- (4) "Controlling person" means any person who directly or indirectly has the power to direct or cause to be directed the management, control, or activities of an intermediary.
- (5) "Intermediary" means any person who acts as a broker, as defined in G.S. 58-33-10(c), in soliciting, negotiating, or procuring the making of any reinsurance contract or binder on behalf of a ceding insurer; or acts as a broker, as defined in G.S. 58-33-10(c), in accepting any reinsurance contract on behalf of an assuming insurer. "Intermediary" includes a broker or a manager, as those terms are defined in this section.
- (6) "Manager" means any person who has authority to bind or manages all or part of the assumed reinsurance business of a reinsurer (including the management of a separate division, department, or underwriting office) and acts as an agent for the reinsurer. The following persons are not managers, with respect to a reinsurer:
  - a. An employee of a reinsurer;
  - b. A United States manager of the United States branch of an alien reinsurer;
  - c. An underwriting manager who, pursuant to contract, manages all the reinsurance operations of a reinsurer, is under common control with the reinsurer under

Article 19 of this Chapter, and whose compensation is not based on the volume of premiums written;

d. The manager of a group, association, pool, or organization of insurers that engages in joint underwriting or joint reinsurance and that is subject to examination by the insurance regulator of the state in which the manager's principal business office is located.

(7) "Producer" means an insurance agent or insurance broker licensed under Article 33 of this Chapter or an intermediary licensed under this Article.

(8) "Qualified United States financial institution" means a bank that:

a. Is organized, or in the case of a United States office of a foreign banking organization is licensed, under the laws of the United States or any state;

b. Is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies; and

c. Has been determined by the Securities Valuation Office of the NAIC to meet its standards of financial condition and standing in order to issue letters of credit.

(9) "Reinsurer" means any licensed insurer that is authorized to assume reinsurance.

(b) No person shall act as a broker in this State if the broker maintains an office either directly, as a member or employee of a noncorporate entity, or as an officer, director, or employee of a corporation:

(1) In this State, unless the broker is a producer in this State; or

(2) In another state, unless the broker is a producer in this State or another state having a law or rule substantially similar to this Article or unless the broker is licensed under this Article as a nonresident intermediary.

(c) No person shall act as a manager:

(1) For a reinsurer domiciled in this State, unless the manager is a producer in this State;

(2) In this State, if the manager maintains an office directly, as a member or employee of a noncorporate entity, or as an officer, director, or employee of a corporation in this State, unless the manager is a producer in this State;

(3) In another state for a foreign insurer, unless the manager is a producer in this State or another state having a law or rule substantially similar to this Article, or the manager is licensed in this State as a nonresident intermediary.

(d) Every manager subject to subsection (c) of this section shall demonstrate to the Commissioner that he has evidence of financial responsibility in the form of fidelity bonds or liability insurance to cover the manager's contractual obligations. If any manager cannot demonstrate this evidence, the Commissioner shall require the manager to:

(1) Maintain a separate fidelity bond in favor of each reinsurer represented in an amount that will cover those obligations and which bond is issued by an authorized insurer; or

(2) Maintain an errors and omissions liability insurance policy in an amount that will cover those obligations and which policy is issued by a licensed insurer. (1993, c. 452, s. 19; 1995, c. 193, s. 20.)

Editor's Note. — Session Laws 1995, c. 193, s. 67, contains a severability clause.

ARTICLE 10.

Miscellaneous Insurer Financial Provisions.

Part 1. Conversion from Stock to Mutual Corporation.

§ 58-10-1. Domestic stock life insurance corporations authorized to convert into mutual corporations; procedure.

Any domestic stock life insurance corporation may become a mutual life insurance corporation, and to that end may carry out a plan for the acquisition of shares of its capital stock: Provided, however, that such plan (i) shall have been adopted by a vote of a majority of the directors of such corporation; (ii) shall have been approved by a vote of the holders of two thirds of the stock outstanding at the time of issuing the call for a meeting for that purpose; (iii) shall have been submitted to the Commissioner and shall have been approved by him in writing, and (iv) shall have been approved by a majority vote of the policyholders (including, for the purpose of this Part, the employer or the president, secretary or other executive officer of any corporation or association to which a master group policy has been issued, but excluding the holders of certificates or policies issued under or in connection with a master group policy) voting at said meeting, called for that purpose, at which meeting only such policyholders whose insurance shall then be in force and shall have been in force for at least one year prior to such a meeting shall be entitled to vote; notice of such a meeting shall be given by mailing such notice, postage prepaid, from the home office of such corporation at least 30 days prior to such meeting to such policyholders at their last known post-office addresses: Provided, that personal delivery of such written notice to any policyholder may be in lieu of mailing the same; and such meeting shall be otherwise provided for and conducted in such a manner as shall be provided in such plan: Provided, however, that policyholders may vote in person, by proxy, or by mail; that all such votes shall be cast by ballot, and a representative of the Commissioner shall supervise and direct the methods and procedure of said meeting and appoint an adequate number of inspectors to conduct the voting at said meeting who shall have power to determine all questions concerning the verification of the ballots, the ascertainment of the validity thereof, the qualifications of the voters, and the canvass of the vote, and who shall certify to the said representative and to the corporation the results thereof, and with respect thereto shall act under such rules and regulations as shall be prescribed by the Commissioner; that all necessary expenses incurred by the Commissioner or his representative shall be paid by the corporation as certified to by said Commissioner. Every payment for the acquisition of any shares of the capital stock of such corporation, the purchase price of which is not fixed by such plan, shall be subject to the approval of the Commissioner: Provided, that neither such plan, nor any payment thereunder, nor any payment not fixed by such plan, shall be approved by the Commissioner, if the making of such payment shall reduce the assets of the corporation to an amount less than the entire liabilities of the corporation, including therein the net values of its outstanding contracts according to the standard adopted by the Commissioner, and also all other funds, contingent reserves and surplus which the corporation is required by order or direction of the Commissioner to maintain, save so much of the surplus as shall have been appropriated or paid under such plan. (1937, c. 231, s. 1; 1991, c. 720, s. 4; 1995, c. 318, s. 1.)

Editor's Note. — Session Laws 1995, c. 318, s. 8, contains a severability clause.

Effect of Amendments. — The 1995 amendment, effective January 1, 1996, rewrote the heading of Article 10, which formerly read "Conversion of Stock Corporations into Mutual Corporations"; added the Part 1 designation and heading; and substituted "Part" for "Article" in subdivision (iv) of the first proviso in the first sentence.

Part 2. Assumption Reinsurance.

§ 58-10-20. Scope.

(a) This Part applies to any licensed insurer that either assumes or transfers the obligations or risks on policies under an assumption reinsurance agreement that is entered into on or after January 1, 1996.

(b) This Part does not apply to:

(1) Any reinsurance agreement or transaction in which the ceding insurer continues to remain directly liable for its insurance obligations or risks under the policies subject to the reinsurance agreement.

(2) The substitution of one insurer for another upon the expiration of insurance coverage under statutory or contractual requirements and the issuance of a new policy by another insurer.

(3) The transfer of policies under mergers or consolidations of two or more insurers to the extent that those transactions are regulated by statute.

(4) Any insurer subject to a judicial order of liquidation or rehabilitation.

(5) Any reinsurance agreement or transaction to which a state insurance guaranty association is a party, provided that policyholders do not lose any rights or claims afforded under their original policies under Articles 48 or 62 of this Chapter.

(6) The transfer of liabilities from one insurer to another under a single group policy upon the request of the group policyholder. (1995, c. 318, s. 1.)

Editor's Note. — Session Laws 1995, c. 318, which enacted this Part, in s. 9 provides that this Part is effective January 1, 1996, and is applicable to assumption reinsurance agreements entered into on or after that date.

Session Laws 1995, c. 318, s. 8, contains a severability clause.

§ 58-10-25. Definitions.

(a) As used in this Part:

(1) Assuming insurer. — The insurer that acquires an insurance obligation or risk from the transferring insurer under an assumption reinsurance agreement.

(2) Assumption reinsurance agreement. — Any contract, arrangement, or plan that:

a. Transfers insurance obligations or risks of existing or in-force policies from a transferring insurer to an assuming insurer.

b. Is intended to effect a novation of transferred policies with the result that the assuming insurer becomes directly liable to the policyholders of the transferring insurer and the transferring insurer's insurance obligations or risks under the policies are extinguished.

(3) Home service business. — Insurance business on which premiums are collected on a weekly or monthly basis by an agent of the insurer.

(4) Policy. — A contract of insurance as defined in G.S. 58-1-10.

(5) Policyholder. — Any person that has the right to terminate or otherwise alter the terms of a policy. It includes any group policy certificate holder whose certificate is in force on the proposed effective date of the assumption, if the certificate holder has the right to keep the certificate in force without any change in benefits after termination of the group policy. The right to keep the certificate in force referred to in this subdivision does not include the right to elect individual coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA"), section 601, et seq., of the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1161, et seq.

(6) Transferring insurer. — The insurer that transfers an insurance obligation or risk to an assuming insurer under an assumption reinsurance agreement.

(b) For the purposes of this Part, a "novation" does not require the formation of a new policy or the amendment of an existing policy between the assuming insurer and the policyholder. (1995, c. 318, s. 1; 1995 (Reg. Sess., 1996), c. 752, s. 2.)

Editor's Note. — The subsection (a) designation was added at the direction of the Revisor of Statutes.

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective June 21, 1996, inserted "arrangement, or plan" following "Any contract" in subdivision (2); in subdivision (2)b., substituted "transferred policies" for "the transferred policy", and substituted "policies" for "contracts" following "risks under the"; and added subsection (b).

§ 58-10-30. Notice requirements.

(a) The transferring insurer shall provide or cause to be provided to each policyholder a notice of transfer by first-class mail, addressed to the policyholder's last known address or to the address to which premium notices or other policy documents are sent; or with respect to home service business, by personal delivery with acknowledged receipt. A notice of transfer shall also be sent to the transferring insurer's agents or brokers of record on the affected policies.

(b) The notice of transfer shall be in a form identical or substantially similar to Appendix A of the NAIC Assumption Reinsurance Model Act, as amended by the NAIC and shall state or provide:

(1) The date on which the transfer and novation of the policyholder's policy is proposed to take place.

(2) The names, addresses, and telephone numbers of the assuming and transferring insurers.

(3) That the policyholder has the right to either consent to or reject the transfer and novation.

(4) The procedures and time limit for consenting to or rejecting the transfer and novation.

(5) A summary of any effect that consenting to or rejecting the transfer and novation will have on the policyholder's rights.

(6) A statement that the assuming insurer is licensed to write the type of business being assumed in the state where the policyholder resides, or is otherwise authorized, as provided in this Part, to assume that business.

(7) The name and address of the person at the transferring insurer to whom the policyholder should send the policyholder's written statement of acceptance or rejection of the transfer and novation.

(8) The address and telephone number of the insurance department where the policyholder resides so that the policyholder may write or call that insurance department for further information about the financial condition of the assuming insurer.

(9) The following financial data for both insurers:

a. Ratings for the last five years, if available, or for any shorter period that is available, from two nationally recognized insurance rating services acceptable to the Commissioner, including the rating services' explanations of the meanings of their ratings. If ratings are unavailable for any year of the five-year period, this shall also be disclosed.

b. A balance sheet as of December 31 for the previous three years, if available, or for any shorter period that is available, and as of the date of the most recent quarterly statement.

c. A copy of the Management's Discussion and Analysis that was filed as a supplement to the previous year's annual statement.

d. An explanation of the reason for the transfer.

(c) The notice of transfer shall include a preaddressed, postage-paid response card that the policyholder may return as the policyholder's written statement of acceptance or rejection of the transfer and novation.

(d) The notice of transfer shall be filed as part of the prior approval requirement set forth in subsection (e) of this section.

(e) Prior approval by the Commissioner is required for any transaction in which a domestic insurer assumes or transfers obligations or risks on policies under an assumption reinsurance agreement. No insurer licensed in this State shall transfer obligations or risks on policies issued to or owned by residents of this State to any insurer that is not licensed in this State. A domestic insurer shall not assume obligations or risks on policies issued to or owned by policyholders residing in any other state unless it is licensed in the other state, or the insurance regulator of that state has approved the assumption.

(f) Any licensed foreign insurer that enters into an assumption reinsurance agreement that transfers the obligations or risks on policies issued to or owned by residents of this State shall file with the Commissioner the assumption certificate, a copy of the notice of transfer, and an affidavit that the transaction is subject to substantially similar requirements in the states of domicile of both the transferring and assuming insurers. If those requirements do not exist in the state of domicile of either the transferring or assuming insurer, the requirements of subsection (g) of this section apply.

(g) Any licensed foreign insurer that enters into an assumption reinsurance agreement that transfers the obligations or risks on policies issued to or owned by residents of this State shall obtain prior approval of the Commissioner and be subject to all other requirements of this Part with respect to residents of this State, unless the transferring and assuming insurers are subject to assumption reinsurance requirements adopted by statute or administrative rule in the states of their domicile that are substantially similar to those contained in this Part and in any administrative rules adopted under this Part.

(h) The following factors, along with any other factors the Commissioner deems to be appropriate under the circumstances, shall be considered by the Commissioner in reviewing a request for approval:

(1) The financial condition of the transferring and assuming insurers and the effect the transaction will have on the financial condition of each company.

(2) The competence, experience, and integrity of those persons who control the operation of the assuming insurer.

(3) The plans or proposals the assuming insurer has with respect to the administration of the policies subject to the proposed transfer.

(4) Whether the transfer is fair and reasonable to the policyholders of both insurers.

(5) Whether the notice of transfer to be provided by the insurer is fair, adequate, and not misleading. (1995, c. 318, s. 1.)

§ 58-10-35. Policyholder rights.

(a) Policyholders may reject the transfer and novation of their policies by indicating on the response card that the assumption is rejected and returning the card to the transferring insurer.

(b) Payment of any premium to the assuming company during the 24-month period after the notice of transfer has been received indicates the policyholder's acceptance of the transfer to the assuming insurer; and a novation shall occur only if the premium notice clearly states that payment of the premium to the assuming insurer constitutes acceptance of the transfer. The premium notice shall also provide a method for the policyholder to pay the premium while reserving the right to reject the transfer. With respect to any home service business or any other business not using premium notices, the disclosures and procedural requirements of this subsection are to be set forth in the notice of transfer required by G.S. 58-10-30 and in the assumption certificate.

(c) After no fewer than 24 months after the mailing of the initial notice of transfer required under G.S. 58-10-30, if positive consent to, or rejection of, the transfer and assumption has not been received or consent has occurred under subsection (b) of this section, the transferring insurer shall send to the policyholder a second and final notice of transfer as specified in G.S. 58-10-30. If the policyholder does not accept or reject the transfer during the one-month period immediately after the date on which the transferring insurer mailed the second and final notice of transfer, the policyholder's consent and novation of the contract will occur. With respect to the home service business, or any other business not using premium notices, the 24-month and one-month periods shall be measured from the date of delivery of the notice of transfer under G.S. 58-10-30.

(d) The transferring insurer shall be deemed to have received the response card on the date it is postmarked. A policyholder may also send the response card by facsimile, other electronic transmission, registered mail, express delivery, or courier service; in which case the response card shall be deemed to have been received by the transferring insurer on the date of actual receipt by the transferring insurer. (1995, c. 318, s. 1.)

§ 58-10-40. Effect of consent.

If a policyholder consents to the transfer under G.S. 58-10-35 or if the transfer is effected under G.S. 58-10-45, there shall be a novation of the policy, subject to the assumption reinsurance agreement, with the result that the transferring insurer is thereby relieved of all insurance obligations or risks transferred under the assumption reinsurance agreement and the assuming insurer is directly and solely liable to the policyholder for those insurance obligations or risks. (1995, c. 318, s. 1.)

§ 58-10-45. Commissioner's discretion.

If a domestic insurer or a foreign insurer from a state having a substantially similar law is deemed by its domiciliary insurance regulator to be in hazardous financial condition or a proceeding has been instituted against it for the purpose of reorganizing or conserving the insurer, and the transfer of the policies is in the best interest of the policyholders, as determined by the domiciliary insurance regulator, a transfer and novation may be effected notwithstanding the provisions of this Part. This may include a form of implied consent and adequate notification to the policyholders of the circumstances requiring the transfer as approved by the Commissioner. (1995, c. 318, s. 1.)

Part 3. Disclosure of Material Transactions.

§ 58-10-55. Report.

(a) This Part applies only to domestic insurers. Effective October 1, 1995, every insurer shall file a report with the Commissioner disclosing material acquisitions and dispositions of assets or material nonrenewals, cancellations, or revisions of ceded reinsurance agreements, unless the acquisitions and dispositions of assets or material nonrenewals, cancellations, or revisions of ceded reinsurance agreements have been submitted to the Commissioner for review, approval, or informational purposes under any other provisions of this Chapter or the North Carolina Administrative Code. This report is due within 15 days after the end of the calendar month in which any of these transactions occurred. A copy of the report, including any filed exhibits or other attachments, shall also be filed with the NAIC.

(b) All reports obtained by or disclosed to the Commissioner under this Part are confidential and are not subject to subpoena. No report shall be made public by the Commissioner, the NAIC, or any other person, except to insurance regulators of other states, without the prior written consent of the reporting insurer, unless the Commissioner, after giving the insurer notice and an opportunity to be heard, determines that the interest of policyholders, shareholders, or the public will be served by the publication of the report. In that event, the Commissioner may publish all or any part of the report in a manner the Commissioner considers appropriate. (1995, c. 318, s. 1.)

Editor's Note. — Session Laws 1995, c. 318, s. 9 made this Part effective January 1, 1996.

Session Laws 1995, c. 318, s. 8, contains a severability clause.

§ 58-10-60. Acquisitions and dispositions of assets.

(a) Insurers do not have to report acquisitions or dispositions under G.S. 58-10-55 if they are not material. For the purposes of this Part, a material acquisition or the aggregate of any series of related acquisitions during any 30-day period, or a material disposition or the aggregate of any series of related dispositions during any 30-day period, is one that is nonrecurring, not in the ordinary course of business, and involves more than five percent (5%) of the insurer's total admitted assets as reported in its most recent financial statement filed with the Department.

(b) Asset acquisitions subject to this Part include every purchase, lease, exchange, merger, consolidation, succession, or other acquisition, other than the construction or development of real property by or for the insurer or the acquisition of materials for that purpose. Asset dispositions subject to this Part include every sale, lease, exchange, merger, consolidation, mortgage, hypothecation, assignment for the benefit of creditors or otherwise, abandonment, destruction, or other disposition.

(c) The following information shall be disclosed in any report under this section:

(1) Date of the transaction.
(2) Manner of acquisition or disposition.
(3) Description of the assets involved.
(4) Nature and amount of the consideration given or received.
(5) Purpose of, or reason for, the transaction.
(6) Manner by which the amount of consideration was determined.
(7) Gain or loss recognized or realized as a result of the transaction.
(8) Name of each person from whom the assets were acquired or to whom they were disposed.

(d) Every insurer shall report material acquisitions and dispositions on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers that uses a pooling arrangement or one hundred percent (100%) reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer ceded substantially all of its direct and assumed business to the pool. An insurer cedes substantially all of its direct and assumed business to a pool if the insurer has less than one million dollars ($1,000,000) total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than five percent (5%) of the insurer's capital and surplus. (1995, c. 318, s. 1.)

§ 58-10-65. Nonrenewals, cancellations, or revisions of ceded reinsurance agreements.

(a) Insurers do not have to report nonrenewals, cancellations, or revisions of ceded reinsurance agreements under G.S. 58-10-55 if they are not material. For the purposes of this Part, a nonrenewal, cancellation, or revision of a ceded reinsurance agreement is considered material and must be reported if:

(1) It is for property and casualty business, including accident and health business written by a property and casualty insurer and affects:
  a. More than fifty percent (50%) of the insurer's total ceded written premium; or
  b. More than fifty percent (50%) of the insurer's total ceded indemnity and loss adjustment reserves.

(2) It is for life, annuity, and accident and health business and affects more than fifty percent (50%) of the total reserve credit taken for business ceded, on an annualized basis, as indicated in the insurer's most recent annual statement.

(3) It is for either property and casualty, or life, annuity, and accident and health business, and:
  a. An authorized reinsurer representing more than ten percent (10%) of a total cession is replaced by one or more unauthorized reinsurers; or
  b. Previously established collateral requirements have been reduced or waived with respect to one or more unauthorized reinsurer's representing collectively more than ten percent (10%) of a total cession.

(b) No filing is required if:

(1) For property and casualty business, including accident and health business written by a property and casualty insurer, the insurer's total ceded written premium represents, on an annualized basis, less than ten percent (10%) of its total written premium for direct and assumed business.

(2) For life, annuity, and accident and health business, the total reserve credit taken for business ceded represents, on an annualized basis, less than ten percent (10%) of the statutory reserve requirement before any cession.

(c) The following information shall be disclosed in any report under this section:

(1) Effective date of the nonrenewal, cancellation, or revision.

(2) Description of the transaction, with an identification of the initiator of the transaction.

(3) Purpose of, or reason for, the transaction.

(4) If applicable, identity of the replacement reinsurers.

(d) Every insurer shall report all material nonrenewals, cancellations, or revisions of ceded reinsurance agreements on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers that uses a pooling arrangement or one hundred percent (100%) reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer ceded substantially all of its direct and assumed business to the pool. An insurer cedes substantially all of its direct and assumed business to a pool if the insurer has less than one million dollars ($1,000,000) total direct plus assumed written premiums during a calendar year that are not subject to the pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than five percent (5%) of the insurer's capital and surplus. (1995, c. 318, s. 1.)

ARTICLE 12.

Risk-Based Capital Requirements.

§ 58-12-2. Definitions.

As used in this Article, the following terms have the following meanings:

(1) Adjusted risk-based capital report. — A risk-based capital report that has been adjusted by the Commissioner under G.S. 58-12-6.

(2) Corrective order. — An order issued by the Commissioner specifying corrective actions that the Commissioner has determined are required.

(3) Domestic insurer. — Any insurance company organized in this State under Article 7 of this Chapter.

(4) Foreign insurer. — Any insurance company that is admitted to do business in this State under Article 16 of this Chapter but is not domiciled in this State.

(4a) Life or health insurer. — Any insurance company licensed to write the kinds of insurance specified in G.S. 58-7-15(1), (2), or (3); or a licensed property and casualty insurer writing only the kinds of insurance specified in G.S. 58-7-15(3).

(5) Negative trend. — A negative trend, with respect to a life or health insurer, over a period of time, as determined in accordance with the "trend test calculation" included in the risk-based capital instructions.

(5a) Property or casualty insurer. — Any insurance company licensed to write the kinds of insurance specified in G.S. 58-7-15(4) through (22); but not monoline mortgage guaranty insurers, financial guaranty insurers, or title insurers.

(6) Risk-based capital instructions. — The risk-based capital report including risk-based capital instructions adopted by the NAIC, as those risk-based capital instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

(7) Risk-based capital level. — An insurer's company action level risk-based capital, regulatory action level risk-based

capital, authorized control level risk-based capital, or mandatory control level risk-based capital where:

- a. "Company action level risk-based capital" means, with respect to any insurer, the product of 2.0 and its authorized control level risk-based capital.
- b. "Regulatory action level risk-based capital" means the product of 1.5 and its authorized control level risk-based capital.
- c. "Authorized control level risk-based capital" means the number determined under the risk-based capital formula in accordance with the risk-based capital instructions.
- d. "Mandatory control level risk-based capital" means the product of .70 and the authorized control level risk-based capital.

(8) Risk-based capital plan. — A comprehensive financial plan containing the elements specified in G.S. 58-12-11(b). If the Commissioner rejects the risk-based capital plan, and it is revised by the insurer, with or without the Commissioner's recommendation, the plan shall be called the "revised risk-based capital plan".

(9) Risk-based capital report. — The report required in G.S. 58-12-6.

(10) Total adjusted capital. — The sum of:

- a. An insurer's statutory capital and surplus, as determined in accordance with the statutory accounting applicable to the annual financial statements required under G.S. 58-2-165; and
- b. Such other items, if any, as the risk-based capital instructions may provide. (1993 (Reg. Sess., 1994), c. 678, s. 1; 1995, c. 318, s. 2.)

Editor's Note. —
Session Laws 1995, c. 318, s. 8, contains a severability clause.

Effect of Amendments. — The 1995 amendment, effective January 1, 1996, substituted "G.S. 58-12-6" for "G.S. 58-12-6(c)" in subdivision (1); deleted "life or health" preceding "insurance company" in subdivisions (3) and (4); added subdivision (4a); added "with respect to a life or health insurer" in subdivision (5); added subdivision (5a); added "as determined in accordance with the statutory accounting applicable to the annual financial statements required under G.S 58-2-165" in subdivision (10); and made stylistic changes.

§ 58-12-4. Finding; endorsement of additional capital.

The General Assembly finds that an excess of capital over the amount produced by the risk-based capital requirements contained in this Article and in the formulas, schedules, and instructions referenced in this Article is desirable in the business of insurance. Accordingly, the General Assembly encourages insurers to seek to maintain capital above the risk-based capital levels required by this Article. Additional capital is used and useful in the insurance business and helps to secure an insurer against various risks inherent in or affecting the business of insurance but not accounted for or only partially measured by the risk-based capital requirements contained in this Article. (1995, c. 318, s. 3.)

Editor's Note. — Session Laws 1995, c. 318, s. 9, made this section effective January 1, 1996.

Session Laws 1995, c. 318, s. 8, contains a severability clause.

§ 58-12-6. Risk-based capital reports.

(a) Every domestic insurer shall, on or before each March 1 (the "filing date"), prepare and submit to the Commissioner a report of its risk-based capital levels as of the end of the calendar year just ended, in a form and containing such information as is required by the risk-based capital instructions. In addition, every domestic insurer shall file its risk-based capital report:

(1) With the NAIC in accordance with the risk-based capital instructions; and

(2) With the insurance regulator in any state in which the insurer is authorized to do business, if the Commissioner has notified the insurer of its request in writing, in which case the insurer shall file its risk-based capital report not later than the later of:

a. Fifteen days after the receipt of notice to file its risk-based capital report with that state; or

b. The filing date.

(b) A life or health insurer's risk-based capital shall be determined in accordance with the formula set forth in the risk-based capital instructions. The formula shall take into account (and may adjust for the covariance between):

(1) The risk with respect to the insurer's assets;

(2) The risk of adverse insurance experience with respect to the insurer's liabilities and obligations;

(3) The interest rate risk with respect to the insurer's business; and

(4) All other business risks and such other relevant risks as are set forth in the risk-based capital instructions.

These risks shall be determined in each case by applying the factors in the manner set forth in the risk-based capital instructions.

(c) If a domestic insurer files a risk-based capital report that in the judgment of the Commissioner is inaccurate, the Commissioner shall adjust the risk-based capital report to correct the inaccuracy and shall notify the insurer of the adjustment. The notice shall contain a statement of the reason for the adjustment. A risk-based capital report as adjusted is referred to as an "adjusted risk-based capital report".

(d) A property or casualty insurer's risk-based capital shall be determined in accordance with the formula set forth in the risk-based capital instructions. The formula shall take into account (and may adjust for the covariance between):

(1) Asset risk;

(2) Credit risk;

(3) Underwriting risk; and

(4) All business and other relevant risks set forth in the risk-based capital instructions, determined in each case by applying the factors in the manner set forth in the risk-based capital instructions. (1993 (Reg. Sess., 1994), c. 678, s. 1; 1995, c. 318, s. 4.)

Editor's Note. — Session Laws 1995, c. 318, s. 8, contains a severability clause.

Effect of Amendments. — The 1995 amendment, effective January 1, 1996, substituted "March 1" for "March 15" in the introductory language of subsection (a); in the first sentence of subsection (b) substituted "A life or health" for "An", and added "capital" preceding "instructions"; and added subsection (d).

§ 58-12-11. Company action level event.

(a) "Company action level event" means any of the following events:

(1) The filing of a risk-based capital report by an insurer that indicates that:
  a. The insurer's total adjusted capital is greater than or equal to its regulatory action level risk-based capital but less than its company action level risk-based capital; or
  b. The insurer has total adjusted capital that is greater than or equal to its company action level risk-based capital but less than the product of its authorized control level risk-based capital and 2.5 and has a negative trend, if the insurer is a life or health insurer.

(2) The notification by the Commissioner to the insurer of an adjusted risk-bases capital report that indicates the event in sub-subdivision (1)a. or b. of this subsection if the insurer does not challenge the adjusted risk-based capital report under G.S. 58-12-30.

(3) If the insurer challenges an adjusted risk-based capital report that indicates the event in sub-subdivision (1)a. or b. of this subsection under G.S. 58-12-30, the notification by the Commissioner to the insurer that the Commissioner has rejected the insurer's challenge.

(b) In the event of a company action level event, the insurer shall prepare and submit to the Commissioner a comprehensive financial plan that:

(1) Identifies the conditions in the insurer that contribute to the company action level event.

(2) Contains proposals of corrective actions that the insurer intends to take and would be expected to result in the elimination of the company action level event.

(3) Provides forecasts of the insurer's financial results in the current year and at least the four succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including forecasts of statutory operating income, net income, capital, or surplus (the forecasts for both new and renewal business should include separate forecasts for each major line of business and separately identify each significant income, expense, and benefit component).

(4) Identifies the key assumptions affecting the insurer's forecasts and the sensitivity of the forecasts to the assumptions.

(5) Identifies the quality of, and problems associated with, the insurer's business, including its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance in each case, if any.

(c) The risk-based capital plan shall be submitted:

(1) Within 45 days after the company action level event; or

(2) If the insurer challenges an adjusted risk-based capital report pursuant to G.S. 58-12-30, within 45 days after notification to the insurer that the Commissioner has rejected the insurer's challenge.

(d) Within 60 days after the submittal by an insurer of a risk-based capital plan to the Commissioner, the Commissioner shall notify the insurer whether the risk-based capital plan shall be implemented or is, in the judgment of the Commissioner, unsatisfactory. If the Commissioner determines the risk-based capital plan is unsatisfactory, the notification to the insurer shall set forth the reasons for the determination, and may set forth proposed revisions that will render the risk-based capital plan satisfactory, in the judgment of the Commissioner. Upon notification from the Commissioner, the insurer shall prepare a revised risk-based capital plan, which may incorporate by reference any revisions proposed by the Commissioner, and shall submit the revised risk-based capital plan to the Commissioner:

(1) Within 45 days after notification from the Commissioner; or

(2) If the insurer challenges the notification from the Commissioner under G.S. 58-12-30, within 45 days after a notification to the insurer that the Commissioner has rejected the insurer's challenge.

(e) In the event of a notification by the Commissioner to an insurer that the insurer's risk-based capital plan or revised risk-based capital plan is unsatisfactory, the Commissioner may, subject to the insurer's right to a hearing under G.S. 58-12-30, specify in the notification that the notification constitutes a regulatory action level event.

(f) Every domestic insurer that files a risk-based capital plan or revised risk-based capital plan with the Commissioner shall file a copy of the risk-based capital plan or revised risk-based capital plan with the insurance regulator in any state in which the insurer is authorized to do business if:

(1) That state has a risk-based capital provision substantially similar to G.S. 58-12-21(a); and

(2) The insurance regulator of that state has notified the insurer of its request for the filing in writing, in which case the insurer shall file a copy of the risk-based capital plan or revised risk-based capital plan in that state no later than the later of:

  a. Fifteen days after the receipt of notice to file a copy of its risk-based capital plan or revised risk-based capital plan with the state; or

  b. The date on which the risk-based capital plan or revised risk-based capital plan is filed under subsection (c) or (d) of this section. (1993 (Reg. Sess., 1994), c. 678, s. 1; 1995, c. 193, s. 21; c. 318, s. 5.)

Editor's Note. —

Session Laws 1995, c. 193, s. 67 and Session Laws 1995, c. 318, s. 8, contain severability clauses.

Effect of Amendments. — Session Laws 1995, c. 193, s. 21, effective June 7, 1995, substituted "subsection (c) or (d) of this section" for "G.S. 58-12-30(c)" at the end of subdivision (f)(2)b.

Session Laws 1995, c. 318, s. 5, effective January 1, 1996, added "if the insurer is a life or health insurer" in subdivision (a)(1)b.

§ 58-12-30. Hearings.

Upon (i) notification to an insurer by the Commissioner of an adjusted risk-based capital report; or (ii) notification to an insurer by the Commissioner that the insurer's risk-based capital plan or revised risk-based capital plan is unsatisfactory, and the notification constitutes a regulatory action level event with respect to the insurer; or (iii) notification to any insurer by the Commissioner that the insurer has failed to adhere to its risk-based capital plan or revised risk-based capital plan and that the failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event with respect to the insurer in accordance with its risk-based capital plan or revised risk-based capital plan; or (iv) notification to an insurer by the Commissioner of a corrective order with respect to the insurer, the insurer has a right to a confidential hearing, at which the insurer may challenge any determination or action by the Commissioner. The insurer shall notify the Commissioner of its request for a hearing within five days after the notification by the Commissioner under this section. Upon receipt of the insurer's request for a hearing, the Commissioner shall set a date for the hearing; the date shall be no less than 10 days nor more than 30 days after the date of the insurer's request. (1993 (Reg. Sess., 1994), c. 678, s. 1; 1995, c. 517, s. 5.)

Editor's Note. —
Session Laws 1995, c. 517, s. 41, contains a severability clause.

§ 58-12-35. Confidentiality and prohibition on announcements.

(a) All risk-based capital reports, to the extent the information therein is not required to be set forth in a publicly available annual statement schedule, and the risk-based capital plans, including the results or report of any examination or analysis of an insurer performed pursuant hereto and any corrective order issued by the Commissioner pursuant to examination or analysis, with respect to any domestic insurer or foreign insurer that are filed with the Commissioner constitute information that shall be kept confidential by the Commissioner. This information shall not be made public or be subject to subpoena, other than by the Commissioner, and then only for the purpose of enforcement actions taken by the Commissioner under this Article or any other provision of this Chapter.

(b) The General Assembly finds that the comparison of an insurer's total adjusted capital to any of its risk-based capital levels is a regulatory tool that may indicate the need for possible corrective action with respect to the insurer, and is not intended as a means to rank insurers generally. Therefore, except as otherwise required under this Article, the making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing an assertion, representation, or statement with regard to the risk-based capital levels of any insurer, or of any component derived in the calculation by any insurer, agent, broker, or other person engaged in any manner in the insurance business is prohibited; provided, however, that if any materially false statement with respect to the comparison regarding an insurer's total adjusted capital to its risk-based capital levels (or any of them) or an inappropriate comparison of any other amount to the insurers' risk-based capital levels is published in any written publication and the insurer is able to demonstrate to the Commissioner, with substantial proof, the falsity of the statement, or the inappropriateness, as the case may be, then the insurer may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement. (1993 (Reg. Sess., 1994), c. 678, s. 1; 1995, c. 193, s. 22.)

Editor's Note. — Session Laws 1995, c. 193, s. 67, contains a severability clause.

Effect of Amendments. — The 1995 amendment, effective June 7, 1995, made "corrective order" lower case in the first sentence of subsection (a).

§ 58-12-40. Supplemental provisions; rules; exemptions.

(a) The provisions of this Article are supplemental to any other provisions of the laws of this State, and do not preclude or limit any other powers or duties of the Commissioner under those laws, including Article 30 of this Chapter.

(b) Risk-based capital instructions, risk-based capital reports, adjusted risk-based capital reports, risk-based capital plans, and revised risk-based capital plans are solely for use by the Commissioner in monitoring the solvency of insurers and the need for possible corrective action with respect to insurers. The Commissioner shall not use any of these reports or plans for rate making nor consider or introduce them as evidence in any rate proceeding. The Commissioner shall not use these reports or plans to calculate or derive any elements of an appropriate premium level or rate of return for any kind of insurance that an insurer or any affiliate is authorized to write.

(c) The Commissioner may exempt from the application of this Article any domestic property or casualty insurer that does all of the following:

(1) Writes direct business only in this State.

(2) Writes direct annual premiums of one thousand dollars ($1,000) or less.

(3) Assumes no reinsurance in excess of five percent (5%) of direct written premiums. (1993 (Reg. Sess., 1994), c. 678, s. 1; 1995, c. 318, s. 6.)

Editor's Note. — Session Laws 1995, c. 318, s. 8, contains a severability clause.

Effect of Amendments. — The 1995 amendment, effective January 1, 1996, added "rules; exemptions" to the end of the catchline; added the subsection (a) designation; and added subsections (b) and (c).

§ 58-12-45. Foreign insurers.

(a) Any foreign insurer shall, upon written request of the Commissioner, submit to the Commissioner a risk-based capital report as of the end of the calendar year just ended the later of:

(1) The date a risk-based capital report would be required to be filed by a domestic insurer under this Article; or
(2) Fifteen days after the request is received by the foreign insurer.

Any foreign insurer shall, at the written request of the Commissioner, promptly submit to the Commissioner a copy of any risk-based capital plan that is filed with the insurance regulator of any other state.

(b) In the event of a company action level event, regulatory action level event, or authorized control level event with respect to any foreign insurer as determined under the risk-based capital statute or rule applicable in the state of domicile of the insurer, or if no risk-based capital statute or rule is in force in that state under the provisions of this Article, if the insurance regulator of the state of domicile of the foreign insurer fails to require the foreign insurer to file a risk-based capital plan in the manner specified under the risk-based capital statute or, if no risk-based capital provision is in force in that state, under G.S. 58-12-11, the Commissioner may require the foreign insurer to file a risk-based capital plan with the Commissioner. In that event the failure of the foreign insurer to file a risk-based capital plan with the Commissioner is grounds to order the insurer to cease and desist from writing new insurance business in this State.

(c) In the event of a mandatory control level event with respect to any foreign insurer, if no domiciliary receiver has been appointed with respect to the foreign insurer under the rehabilitation or liquidation statutes of the state of domicile of the foreign insurer, the Commissioner may make application to the Superior Court of Wake County as permitted under Article 30 of this Chapter with respect to the liquidation of property of foreign insurers found in this State; and the occurrence of the mandatory control level event is an adequate ground for the application. (1993 (Reg. Sess., 1994), c. 678, s. 1; 1995, c. 193, s. 23.)

Editor's Note. — Session Laws 1995, c. 193, s. 67, contains a severability clause.

Effect of Amendments. — The 1995 amendment, effective June 7, 1995, in the first sentence of subsection (b), substituted "event, regulatory action level event, or authorized control level event" for "event or regulatory action level event", inserted "or rule" following "capital statute", and substituted "statute or rule" for "provision" following "risk-based capital"; and substituted "of" for "or" preceding "domicile of" in subsection (c).

§ 58-12-60. Property or casualty phase-in provision.

For risk-based capital reports required to be filed by property or casualty insurers with respect to 1995, the following requirements apply in lieu of the provisions of G.S. 58-12-11, 58-12-16, 58-12-21, and 58-12-25:

(1) In the event of a company action level event with respect to a domestic insurer, the Commissioner shall take no regulatory action under this Article.
(2) In the event of a regulatory action level event under G.S. 58-12-16(a)(1), (2), or (3), the Commissioner shall take the actions required under G.S. 58-12-11.

(3) In the event of a regulatory action level event under G.S. 58-12-16(a)(4), (5), (6), (7), (8), or (9), or an authorized control level event, the Commissioner shall take the actions required under G.S. 58-12-16 with respect to the insurer.
(4) In the event of a mandatory control level event with respect to an insurer, the Commissioner shall take the actions required under G.S. 58-12-21 with respect to the insurer. (1995, c. 318, s. 7.)

Editor's Note. — Session Laws 1995, c. 318, s. 9, made this section effective January 1, 1996.

Session Laws 1995, c. 318, s. 8, contains a severability clause.

ARTICLE 14.

Unauthorized Insurance by Domestic Companies.

§ 58-14-15. Penalties provided for unauthorized acts.

When any domestic insurer knowingly engages in the practice of soliciting, advertising or making contracts for insurance in states or jurisdictions in which it is not licensed, the Commissioner may issue an order requiring the company to cease and desist from engaging in such activities and, for the purposes of this section, the acts prohibited by G.S. 58-14-10 and the foregoing sections, are declared to be an unfair trade practice within the meaning of G.S. 58-63-15 and G.S. 58-63-40. When the Commissioner has reason to believe that any domestic company has been engaged or is engaging in the practice of knowingly soliciting, advertising or writing contracts of insurance on risks within a state or jurisdiction in which it is not licensed, the Commissioner shall serve the company with notice of hearing and the hearing shall conform with the hearing procedure set forth in G.S. 58-63-25. Any action taken by the Commissioner after the hearing shall comply with G.S. 58-63-32, and any company aggrieved by an order of the Commissioner is entitled to the judicial review provided in G.S. 58-63-35. (1967, c. 935, s. 1; 1991, c. 720, ss. 4, 54; 1995, c. 193, s. 24; 1995 (Reg. Sess., 1996), c. 742, s. 23.)

Editor's Note. —
Session Laws 1995, c. 193, s. 67, contains a severability clause.

Effect of Amendments. — The 1995 amendment, effective June 7, 1995, substituted "may" for "shall be authorized, as hereinafter provided to" in the first sentence; substituted "the Commissioner shall serve the company" for "he shall proceed to serve such company" in the second sentence; substituted "G.S. 58-63-32" for "G.S. 58-63-30" in the last sentence; and made stylistic changes throughout the section.

The 1995 (Reg. Sess., 1996) amendment, effective June 21, 1996, inserted "G.S." preceding "58-63-40" in the first sentence.

ARTICLE 16.

Foreign or Alien Insurance Companies.

§ 58-16-5. Conditions of admission.

A foreign or alien insurance company may be admitted and authorized to do business when it:

(1) Deposits with the Commissioner a certified copy of its charter or certificate of organization and a statement of its financial condition and business, in such form and detail as he requires, signed and sworn to by its president and secretary or other proper officer, and pays for the filing of this statement the sum required by law.

(2) Satisfies the Commissioner that it is fully and legally organized under the laws of its state or government to do the business it proposes to transact, and that it has been successful in the conduct of such business; that it has, if a stock company, a free surplus and a fully paid-up and unimpaired capital, exclusive of stockholders' obligations of any description of an amount not less than that required for the organization of a domestic company writing the same kinds of business; and if a mutual company that its free surplus is not less than that required for the organization of a domestic company writing the same kind of business, and that such capital, surplus, and other funds are invested in substantial accordance with the requirements of Articles 1 through 64 of this Chapter.

(3) Repealed by Session Laws 1995, c. 517, s. 6, effective July 29, 1995.

(4) Repealed by Session Laws 1987, c. 629, s. 20, effective February 1, 1988.

(5) Files with the Commissioner a certificate that it has complied with the laws of the state or government under which it was organized and is authorized to make contracts of insurance.

(6) Satisfies the Commissioner that it is in substantial compliance with the provisions of G.S. 58-7-21, 58-7-26, 58-7-30, and 58-7-31 and Article 13 of this Chapter.

(7) Satisfies the Commissioner that it is in compliance with the company name requirements of G.S. 58-7-35. (1899, c. 54, s. 62; 1901, c. 391, s. 5; 1903, c. 438, s. 6; Rev., s. 4747; C.S., s. 6411; 1945, c. 384; 1951, c. 781, s. 3; 1985 (Reg. Sess., 1986), c. 1027, s. 32; 1987, c. 629, s. 20; 1987 (Reg. Sess., 1988), c. 975, s. 16; 1991, c. 681, s. 24; 1995, c. 193, s. 25; c. 517, s. 6.)

Editor's Note. — Session Laws 1995, c. 193, s. 67 and Session Laws 1995, c. 517, s. 41 contain severability clauses.

§ 58-16-6. Conditions of continued licensure.

In order for a foreign insurance company to continue to be licensed, it shall report any changes in the documents filed under G.S. 58-16-5(1) or G.S. 58-16-5(5), maintain the amounts of capital and surplus specified in G.S. 58-16-5(2), and remain in substantial compliance with the statutes listed in G.S. 58-16-5(6) and G.S. 58-16-5(7). (1995, c. 517, s. 7.)

Editor's Note. — Session Laws 1995, c. 517, c. 42, made this section effective October 1, 1995.

Session Laws 1995, c. 517, s. 41, contains a severability clause.

§ 58-16-20. Company owned or controlled by foreign government prohibited from doing business.

(a) Any insurance company or other insurance entity that is owned or controlled by any foreign government outside the continental limits of the United States or the territories of the United States is prohibited from doing any kind of insurance business in the State of North Carolina. For the purposes of this section, "foreign government" means any foreign government or any state, province, municipality, or political subdivision of any foreign government, and shall not be construed to apply to any insurance company organized under the laws of a foreign nation that is owned or controlled by the private citizens or private business interest of that foreign nation.

(b) The Commissioner shall not license any insurance company or other insurance entity that is owned or controlled by any foreign government outside the continental limits of the United States or the territories of the United States, nor shall the Commissioner authorize any such company or entity to transact any kind of insurance business in the State of North Carolina.

(c) Any insurance company or other insurance entity that is owned or controlled by any foreign government outside the continental limits of the United States or the territories of the United States, or any representative or agent of any such company or entity that violates the provisions of this section, is guilty of a Class 3 misdemeanor.

(d) This section does not apply to the operating subsidiary of any insurance company or other insurance entity, where the company or entity is owned or controlled by any foreign government outside the continental limits of the United States or the territories of the United States, as long as the operating subsidiary is domesticated in and licensed by another state of the United States as an insurer or reinsurer and as a separate subsidiary. (1955, c. 449; 1991, c. 720, s. 4; 1993, c. 539, s. 449; 1994, Ex. Sess., c. 24, s. 14(c); 1997-179, s. 1.)

Effect of Amendments. — The 1997 amendment, effective October 1, 1997, and applicable to acts committed and applications for licensure submitted on or after that date, substituted "foreign" for "alien" in the catchline; deleted "financially" throughout the section; deleted "alien or" preceding "foreign government" in subsections (a), (b) and (c); in subsection (a), substituted "that" for "which" following "entity", deleted "hereby" preceding "prohibited from", substituted "'foreign government' means" for "the term 'alien or foreign government' is defined to mean", substituted "that" for "which" following "foreign nation" and "that" for "such" preceding "foreign nation"; in subsection (b), substituted "shall not license any" for "is hereby forbidden to grant a license to", "that" for "which" following "entity", and substituted "nor shall the Commissioner" for "or to"; in subsection (c), twice substituted "that" for "which" following "entity", and "is" for "shall be" preceding "guilty of"; and added subsection (d).

§ 58-16-30. Service of legal process upon Commissioner.

As an alternative to service of legal process under G.S. 1A-1, Rule 4, the service of such process upon any insurance company or any foreign or alien entity licensed or admitted and authorized to do business in this State under the provisions of this Chapter may be made by the sheriff or any other person delivering and leaving a copy of the process in the office of the Commissioner with a deputy or any other person duly appointed by the Commissioner for that purpose; or acceptance of service of the process may be made by the Commissioner or a duly appointed deputy or person. Service may also be made by mailing a copy of the summons and of the complaint, registered or certified mail, return receipt requested, addressed to the Commissioner. As a condition precedent to a valid service of process under this section, the party obtaining such service shall pay to the Commissioner at the time of service or acceptance of service the sum of ten dollars ($10.00), which the party shall recover as part of the taxable costs if the party prevails in the action. (1899, c. 54, ss. 16, 62; 1903, c. 438, s. 6; Rev., s. 4750; C.S., s. 6414; 1927, c. 167, s. 1; 1931, c. 287; 1951, c. 781, s. 9; 1971, c. 421, s. 1; 1985, c. 666, s. 5; 1989, c. 645, s. 2; 1991, c. 720, s. 4; 1995, c. 517, s. 8.)

Editor's Note. — Session Laws 1995, c. 517, s. 41, contains a severability clause.

ARTICLE 18.

Promoting and Holding Companies.

§ 58-18-25. Application fee.

Editor's Note. —

Session Laws 1995, c. 507, s. 11A(c), amended Session Laws 1989 (Reg. Sess., 1990), c. 1069, s. 31, deleting the last sentence regarding the expiration of amendments to the General Statutes by Session Laws 1989 (Reg. Sess., 1990), c. 1069, if the legislature did not appropriate or transfer funds. Session Laws 1989 (Reg. Sess., 1990), s. 31, as amended by Session Laws 1995, c. 507, s. 11A(c), provides: "Section 23 [see § 58-36-70] of this act does not apply to the 1990 automobile rate filing made pursuant to Article 36 of Chapter 58 of the General Statutes. Section 27 [§ 143-3.6] of this act shall expire at the end of the 1993-1994 fiscal year and Section 28 [§ 143-3.7] shall become effective upon the expiration of Section 27."

Session Laws 1995, c. 507, s. 1.1, provides that that act shall be known and cited as the Expansion and Capital Improvements Appropriations Act of 1995.

Session Laws 1995, c. 507, s. 28.9, provides: "Except for statutory changes or other provisions that clearly indicate an intention to have effects beyond the 1995-97 fiscal biennium, the textual provisions of this act apply only to funds appropriated for, and activities occurring during, the 1995-97 biennium."

ARTICLE 19.

Insurance Holding Company System Regulatory Act.

§ 58-19-5. Definitions.

As used in this Article, unless the context requires otherwise, the following terms have the following meanings:

(1) An "affiliate" of or person "affiliated" with a specific person is a person that indirectly through one or more intermediaries or directly controls, is controlled by, or is under common control with the person specified.

(2) "Control", including the terms "controlling", "controlled by", and "under common control with", means the direct or indirect possession of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise. Control is presumed to exist if any person directly or indirectly owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by G.S. 58-19-25(j) that control does not exist in fact. The Commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

(3) "Insurance holding company system" means an entity comprising two or more affiliated persons, one or more of which is an insurer.

(4) "Insurer" includes a person subject to Articles 65 and 66 or 67 of this Chapter. "Insurer" does not include (1) an agency, authority, or instrumentality of the United States; any of its possessions and territories; the Commonwealth of Puerto Rico; the District of Columbia; nor a state or political subdivision of a state; nor (2) fraternal benefit societies or fraternal orders.

(5) "Person" means an individual, corporation, partnership, association, joint stock company, trust, unincorporated organization, or any similar entity or any combination of the foregoing acting in concert.

(6) A "security holder" of a specified person is one who owns any security of such person, including common stock, preferred stock, debt obligations, or any other security convertible into or evidencing the right to acquire any of the foregoing.

(7) A "subsidiary" of a specified person is an affiliate controlled by such person indirectly through one or more intermediaries or directly.

(8) "Voting security" includes any security convertible into or evidencing a right to acquire a voting security. (1989, c. 722, s. 1; 1995, c. 517, ss. 9, 10.)

Editor's Note. — Session Laws 1995, c. 517, s. 41, contains a severability clause.

§ 58-19-15. Acquisition of control of or merger with domestic insurer.

(a) No person other than the issuer shall make a tender offer for or a request or invitation for tenders of, or enter into any agreement to exchange securities, or seek to acquire, or acquire, in the open market or otherwise, any voting security of a domestic insurer, if, after the consummation thereof, the person would, directly or indirectly (or by conversion or by exercise of any right to acquire), be in control of the insurer, and no person shall enter into an agreement to merge with or otherwise to acquire control of a domestic insurer or any person controlling a domestic insurer unless the offer, request, invitation, agreement, or acquisition is conditioned upon the approval of the Commissioner under this section. No such merger or other acquisition of control is effective until a statement containing the information required by this section has been filed with the Commissioner and all other provisions of this section have been complied with and the merger or acquisition of control has been approved by the Commissioner under this section. The statement containing the information required by this section shall also be filed with the domestic insurer when it is filed with the Commissioner.

(a1) For the purposes of this section a "domestic insurer" includes any person controlling a domestic insurer. Further, for the purposes of this section, "person" does not include any securities broker holding, in the usual and customary broker's function, less than twenty percent (20%) of the voting securities of an insurance company or of any person that controls an insurance company.

(a2) Any acquisition of control of a domestic insurer must be completed not later than 90 days after the date of the Commissioner's order approving the acquisition under this section, unless the Commissioner grants an extension in writing on a showing of good cause for the delay. Any increase in a company's capital and surplus required under this Article as a result of the change of control of a domestic insurer must be completed not later than 90 days after the date of the Commissioner's order approving the change of control and before the company writes any new insurance business.

(a3) If the deadlines for completion in subsection (a2) of this section are not met, the person seeking to acquire control of the domestic insurer must resubmit the statement required by subsection (b) of this section, and the Commissioner may reconsider approval of acquisition of control under this section.

(b) The statement to be filed with the Commissioner under subsection (a) of this section shall be made under oath or affirmation and shall contain the following information:

(1) The name and address of each person by whom or on whose behalf the merger or other acquisition of control referred to in subsection (a) of this section is to be effected (hereinafter called "acquiring party"), and: (i) if such person is an individual, his principal occupation and all offices and positions held during the past five years, and any conviction of crimes other than minor traffic violations during the

past 10 years; (ii) if such person is not an individual, a report of the nature of its business operations during the past five years or for such lesser period as such person and any predecessors thereof shall have been in existence; an informative description of the business intended to be done by such person and such person's subsidiaries; and a list of all individuals who are or who have been selected to become directors or executive officers of such person, or who perform or will perform functions appropriate to such positions. Such list shall include for each such individual the information required by sub-subdivision (1)(i) of this subsection.

(2) The source, nature, and amount of the consideration used or to be used in effecting the merger or other acquisition of control; a description of any transaction wherein funds were or are to be obtained for any such purpose, including any pledge of the insurer's stock, or the stock of any of its subsidiaries or controlling affiliates; and the identity of persons furnishing such consideration; provided, however, that where a source of such consideration is a loan made in the lender's ordinary course of business, the identity of the lender shall remain confidential, if the person filing such statement so requests.

(3) Fully audited financial information as to the earnings and financial condition of each acquiring party for the preceding five fiscal years of each such acquiring party, or for such lesser period as such acquiring party and any predecessors thereof have been in existence; and similar unaudited information as of a date not earlier than 90 days prior to the filing of the statement.

(4) Any plans or proposals that each acquiring party may have to liquidate such insurer, to sell its assets or merge or consolidate it with any person, or to make any other material change in its business or corporate structure or management.

(5) The number of shares of any security referred to in subsection (a) of this section that each acquiring party proposes to acquire; the terms of the offer, request, invitation, agreement, or acquisition referred to in subsection (a) of this section; and a statement as to the method by which the fairness of the proposal was arrived at.

(6) The amount of each class of any security referred to in subsection (a) of this section that is beneficially owned or concerning which there is a right to acquire beneficial ownership by each acquiring party.

(7) A full description of any contracts, arrangements, or understandings with respect to any security referred to in subsection (a) of this section in which any acquiring party is involved, including transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. Such description shall identify the persons with whom such contracts, arrangements, or understandings have been entered into.

(8) A description of the purchase of any security referred to in subsection (a) of this section during the 12 calendar months

preceding the filing of the statement, by any acquiring party, including the dates of purchase, names of the purchasers, and consideration paid or agreed to be paid therefor.

(9) A description of any recommendations to purchase any security referred to in subsection (a) of this section made during the 12 calendar months preceding the filing of the statement, by any acquiring party, or by anyone based upon interviews or at the suggestion of such acquiring party.

(10) Copies of all tender offers for, requests, or invitations for tenders of, exchange offers for, and agreements to acquire or exchange any securities referred to in subsection (a) of this section, and any related additional soliciting material that has been distributed.

(11) The term of any agreement, contract, or understanding made with or proposed to be made with any third party in connection with any acquisition of control of or merger with a domestic insurer, and the amount of any fees, commissions, or other compensation to be paid to the third party with regard thereto.

(12) Such additional information as the Commissioner may by rule prescribe as necessary or appropriate for the protection of policyholders of the insurer or in the public interest.

If the person required to file the statement referred to in subsection (a) of this section is a partnership, limited partnership, syndicate, or other group, the Commissioner shall require that the information called for by subdivisions (1) through (12) of this subsection be given with respect to each partner of such partnership or limited partnership, each member of such syndicate or group, and each person who controls such partner or member. If any such partner, member, or person is a corporation or the person required to file the statement referred to in subsection (a) of this section is a corporation, the Commissioner shall require that the information called for by subdivisions (1) through (12) of this subsection be given with respect to such corporation, each officer and director of such corporation, and each person who is, directly or indirectly, the beneficial owner of more than ten percent (10%) of the outstanding voting securities of such corporation.

If any material change occurs in the facts set forth in the statement filed with the Commissioner and sent to such insurer pursuant to this section, an amendment setting forth such change, together with copies of all documents and other material relevant to such change, shall be filed with the Commissioner and sent to such insurer by the filer within two business days after the person learns of such change.

(c) If any offer, request, invitation, agreement, or acquisition referred to in subsection (a) of this section is proposed to be made by means of a registration statement under the Federal Securities Act of 1933, in circumstances requiring the disclosure of similar information under the Federal Securities Exchange Act of 1934, or under any State law requiring similar registration or disclosure, the person required to file the statement referred to in subsection (a) may utilize such documents in furnishing the information called for by that statement.

(d) The Commissioner shall approve any merger or other acquisition of control referred to in subsection (a) of this section unless, after a public hearing thereon, he finds any of the following:

(1) After the change of control, the domestic insurer referred to in subsection (a) of this section would not be able to satisfy the requirements for the issuance of a license to write the kind or kinds of insurance for which it is presently licensed.

(2) The effect of the merger or other acquisition of control would be substantially to lessen competition in insurance or tend to create a monopoly in this State.

(3) The financial condition of any acquiring party might jeopardize the financial stability of the insurer or prejudice the interest of its policyholders.

(4) Any plans or proposals that the acquiring party has to liquidate the insurer, sell its assets or consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management, are unfair and unreasonable to policyholders of the insurer and not in the public interest.

(5) The competence, experience, and integrity of those persons who would control the operation of the insurer are such that it would not be in the interests of policyholders of the insurer and of the public to permit the merger or other acquisition of control.

(6) The acquisition is likely to be hazardous or prejudicial to the insurance-buying public.

(e) The public hearing referred to in subsection (d) of this section shall be held within 120 days after the statement required by subsection (a) of this section is filed, and the Commissioner shall give at least 30 days notice of the hearing to the person filing the statement, to the insurer, and to such other persons as may be designated by the Commissioner. The Commissioner shall make a determination as expeditiously as is reasonably practicable after the conclusion of the hearing. At the hearing, the person filing the statement, the insurer, any person to whom notice of hearing was sent, and any other person whose interest may be affected by the hearing shall have the right to present evidence, examine and cross-examine witnesses, and offer oral or written arguments; and in connection therewith shall be entitled to conduct discovery proceedings at any time after the statement is filed with the Commissioner under this section and in the same manner as is presently allowed in the superior courts of this State. In connection with discovery proceedings authorized by this section, the Commissioner may issue such protective orders and other orders governing the timing and scheduling of discovery proceedings as might otherwise have been issued by a superior court of this State in connection with a civil proceeding. If any party fails to make reasonable and adequate response to discovery on a timely basis or fails to comply with any order of the Commissioner with respect to discovery, the Commissioner on the Commissioner's own motion or on motion of any other party or person may order that the hearing be postponed, recessed, convened, or reconvened, as the case may be, following proper completion of discovery and reasonable notice to the person filing the statement, to the insurer, and to such other persons as may be designated by the Commissioner.

(f) The Commissioner may retain, at the acquiring person's expense, any attorneys, actuaries, economists, accountants, or other experts not otherwise a part of the Commissioner's staff as may be reasonably necessary to assist the Commissioner in reviewing the proposed acquisition of control.

(g) The expenses of mailing any notices and other materials required by this section shall be borne by the person making the filing. As security for the payment of such expenses, such person shall file with the Commissioner an acceptable bond or other deposit in an amount to be determined by the Commissioner.

(h) The provisions of this section do not apply to any offer, request, invitation, agreement, or acquisition that the Commissioner by order exempts therefrom as (i) not having been made or entered into for the purpose and not having the effect of changing or influencing the control of a domestic insurer, or (ii) as otherwise not comprehended within the purposes of this section.

(i) The following are violations of this section:

(1) The failure to file any statement, amendment, or other material required to be filed pursuant to subsection (a) or (b) of this section; or

(2) The effectuation or any attempt to effectuate an acquisition of control of or merger with a domestic insurer, unless the Commissioner has given his approval thereto.

(j) The courts of this State are vested with jurisdiction over every person not resident, domiciled, or authorized to do business in this State who files a statement with the Commissioner under this section; and each such person is deemed to have performed acts equivalent to and constituting an appointment by such person of the Commissioner to be his true and lawful attorney upon whom may be served all legal process in any action, suit, or proceeding arising out of violations of this section. Copies of all such process shall be handled in accordance with the provisions of G.S. 58-16-30, 58-16-35, and 58-16-45. (1989, c. 722, s. 1; 1991, c. 681, ss. 31, 32; c. 720, s. 17; 1993, c. 452, ss. 26-29; c. 504, s. 12; c. 553, s. 16; 1995, c. 517, ss. 11, 12.)

Editor's Note. —
Session Laws 1995, c. 517, s. 41, contains a severability clause.

CASE NOTES

Editor's Note. — *Most of the opinions below were decided under former § 58-9-5 prior to its repeal.*

Notice and Hearing Required. — Because there may be circumstances in which a corporate reorganization might work to the detriment of the domestic insurance company or its shareholders or policyholders, the corporate reorganization could be accomplished only after notice was given to all shareholders and to the public of a public hearing which the Commissioner of Insurance was directed to hold. Occidental Life Ins. Co. v. Ingram, 34 N.C. App. 619, 240 S.E.2d 460 (1977).

Commissioner Must Act in Good Faith. — A clearly implied condition upon the powers conferred upon the Commissioner by former § 58-9-9 was that he will exercise them in good faith. Occidental Life Ins. Co. v. Ingram, 34 N.C. App. 619, 240 S.E.2d 460 (1977).

And Not Arbitrarily. — The powers conferred upon the Commissioner of Insurance were not so broad as to permit him arbitrarily to refuse to make findings favorable to petitioners when all of the evidence supported such findings and there was no competent evidence to the contrary. Occidental Life Ins. Co. v. Ingram, 34 N.C. App. 619, 240 S.E.2d 460 (1977).

The Commissioner of Insurance abused the powers granted to him by the General Assembly when he arbitrarily and capriciously denied a domestic insurance company's plan to reorganize under a holding company structure where all of the competent evidence showed it was clearly entitled to reorganization. Occidental Life Ins. Co. v. Ingram, 34 N.C. App. 619, 240 S.E.2d 460 (1977).

Relief from Commissioner's Arbitrary Action. — If the Commissioner acts arbitrarily, petitioners are not left helpless, nor are the courts powerless to grant them adequate relief. Occidental Life Ins. Co. v. Ingram, 34 N.C. App. 619, 240 S.E.2d 460 (1977).

Issuance of Mandatory Injunction Requiring Commissioner to Act Upheld. — The trial court did not exceed its power and authority by issuing its mandatory injunction requiring the Commissioner of Insurance to approve a domestic insurance corporation's plan to reorganize under a holding company structure where the Commissioner acted arbitrarily and capriciously when he disapproved the plan. Occidental Life Ins. Co. v. Ingram, 34 N.C. App. 619, 240 S.E.2d 460 (1977).

§ 58-19-25. Registration of insurers.

(a) Every insurer that is licensed to do business in this State and that is a member of an insurance holding company system shall register with the Commissioner, except a foreign insurer subject to the registration requirements and standards adopted by statute or regulation in the jurisdiction of its domicile that are substantially similar to those contained in this section and G.S. 58-19-30 or a provision such as the following: Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions within 15 days after the end of the month in which it learns of each change or addition. The insurer shall also file a copy of its registration statement and any amendments to the statement in each state in which that insurer is authorized to do business if requested by the insurance regulator of that state. Any insurer that is subject to registration under this section shall register within 30 days after it becomes subject to registration, and an amendment to the registration statement shall be filed by March 1 of each year for the previous calendar year; unless the Commissioner for good cause shown extends the time for registration or filing, and then within the extended time. All registration statements shall contain a summary, on a form prescribed by the Commissioner, outlining all items in the current registration statement representing changes from the prior registration statement. The Commissioner may require any insurer that is a member of a holding company system that is not subject to registration under this section to furnish a copy of the registration statement or other information filed by the insurance company with the insurance regulator of its domiciliary jurisdiction.

(b) Every insurer subject to registration shall file the registration statement on a form prescribed by the Commissioner, which shall contain the following current information:

(1) The bylaws, capital structure, general financial condition, ownership, and management of the insurer and any person controlling the insurer.

(2) The identity and relationship of every member of the insurance holding company system.

(3) The following agreements in force, and transactions currently outstanding or that have occurred during the last calendar year between such insurer and its affiliates:

a. Loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the insurer or of the insurer by its affiliates.

b. Purchases, sales, or exchange of assets.

c. Transactions not in the ordinary course of business.

d. Guarantees or undertakings for the benefit of an affiliate that result in an actual contingent exposure of the insurer's assets to liability, other than insurance contracts entered into in the ordinary course of the insurer's business.

e. All management agreements, service contracts, and cost-sharing arrangements.

f. Reinsurance agreements.

g. Dividends and other distributions to shareholders.

h. Consolidated tax allocation agreements.

(4) Any pledge of the insurer's stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system.

(5) Other matters concerning transactions between registered insurers and any affiliates as may be included from time to time in any registration forms adopted or approved by the Commissioner.

(c) No information need be disclosed on the registration statement filed pursuant to subsection (b) of this section if such information is not material for the purposes of this section. Unless the Commissioner by rule or order provides otherwise, all sales, purchases, exchanges, loans or extensions of credit, investments, or guarantees involving one-half of one percent (½%) or less of an insurer's admitted assets as of the preceding December 31 are not material for the purposes of this section.

(d) Subject to G.S. 58-19-30(c), each domestic insurer shall report to the Commissioner all dividends and other distributions to shareholders within 15 business days following the declaration thereof. The Commissioner may prescribe the form to be used to report that information.

(e) Any person within an insurance holding company system subject to registration shall provide complete and accurate information to an insurer, where such information is reasonably necessary to enable the insurer to comply with the provisions of this Article.

(f) The Commissioner shall terminate the registration of any insurer that demonstrates that it no longer is a member of an insurance holding company system.

(g) The Commissioner may require or allow two or more affiliated insurers subject to registration under this section to file a consolidated registration statement.

(h) The Commissioner may allow an insurer that is authorized to do business in this State and that is part of an insurance holding company system to register on behalf of any affiliated insurer that is required to register under subsection (a) of this section and to file all information and material required to be filed under this section.

(i) The provisions of this section do not apply to any insurer, information, or transaction if and to the extent that the Commissioner by rule or order exempts the same from the provisions of this section.

(j) Any person may file with the Commissioner a disclaimer of affiliation with any authorized insurer, or such a disclaimer may be filed by such insurer or any member of an insurance holding company system. The disclaimer shall fully disclose all material relationships and bases for affiliation between such person and such insurer as well as the basis for disclaiming such affiliation. After a disclaimer has been filed, the insurer shall be relieved of any duty to register or report under this section that may arise out of the insurer's relationship with such person unless the Commissioner disallows such a disclaimer. The Commissioner shall disallow such a disclaimer only after furnishing all parties in interest with notice and opportunity to be heard and after making specific findings of fact to support such disallowance.

(k) The failure to file a registration statement or any summary of the registration statement thereto required by this section within the time specified for such filing is a violation of this section. (1989, c. 722, s. 1; 1991, c. 681, ss. 33, 34; 1993, c. 452, ss. 30-32; c. 504, s. 13; 1993 (Reg. Sess., 1994), c. 678, s. 14; 1995, c. 193, s. 26.)

Editor's Note. —

Session Laws 1995, c. 193, s. 67, contains a severability clause.

§ 58-19-35. Examination.

(a) Subject to the limitation contained in this section and in addition to the powers that the Commissioner has under other provisions of Articles 1 through 64 of this Chapter relating to the examination of insurers, the Commissioner also has the power to order any insurer registered under G.S. 58-19-25 or any acquiring party to produce such records, books, or other information in the possession of the insurer or its affiliates or the acquiring party as are reasonably necessary to ascertain the financial condition of such insurer or acquiring party or to determine compliance with Articles 1 through 64 of this Chapter. In the event such insurer or acquiring party fails to comply with such order, the Commissioner shall have the power to examine such insurer or its affiliates or such acquiring party to obtain such information.

(b) The Commissioner may retain, at the expense of the registered insurer or acquiring party that is being examined, such attorneys, actuaries, economists, accountants, and other experts not otherwise a part of the Commissioner's staff as are reasonably necessary to assist in the conduct of the examination under subsection (a) of this section. Any persons so retained shall be under the direction and control of the Commissioner and shall act in a purely advisory capacity.

(c) Repealed by Session Laws 1995, c. 360, s. 2(h), effective July 1, 1995.

(d) The Commissioner shall exercise his power under subsection (a) of this section only if the examination of the insurer or acquiring party under other provisions of Articles 1 through 64 of this Chapter is inadequate or the interests of the policyholders of such insurer may be adversely affected. (1989, c. 722, s. 1; 1995, c. 193, s. 27; c. 360, s. 2(h).)

Editor's Note. —

Prior to its repeal by Session Laws 1995, c. 360, s. 2(h), effective July 1, 1995, subsection (c) was amended by Session Laws 1995, c. 193, s. 27, effective June 7, 1995. From June 7, 1995 to July 1, 1995, subsection (c) read: "Each registered insurer or acquiring party producing records, books, or papers for examination pursuant to subsection (a) of this section is liable for and shall pay the expenses of the examination in accordance with G.S. 58-2-133 and G.S. 58-6-5."

Session Laws 1995, c. 193, s. 67, contains a severability clause.

Article 21.

Surplus Lines Act.

§ 58-21-20. Eligible surplus lines insurers required.

Editor's Note. —

Session Laws 1995, c. 507, s. 11A(c), amended Session Laws 1989 (Reg. Sess., 1990), c. 1069, s. 31, deleting the last sentence regarding the expiration of amendments to the General Statutes by Session Laws 1989 (Reg. Sess., 1990), c. 1069, if the legislature did not appropriate or transfer funds. Session Laws 1989 (Reg. Sess., 1990), s. 31, as amended by Session Laws 1995, c. 507, s. 11A(c), provides: "Section 23 [see § 58-36-70] of this act does not apply to the 1990 automobile rate filing made pursuant to Article 36 of Chapter 58 of the General Statutes. Section 27 [§ 143-3.6] of this act shall expire at the end of the 1993-1994 fiscal year and Section 28 [§ 143-3.7] shall become effective upon the expiration of Section 27."

Session Laws 1995, c. 507, s. 1.1, provides that that act shall be known and cited as the Expansion and Capital Improvements Appropriations Act of 1995.

Session Laws 1995, c. 507, s. 28.9, provides: "Except for statutory changes or other provisions that clearly indicate an intention to have effects beyond the 1995-97 fiscal biennium, the textual provisions of this act apply only to funds appropriated for, and activities occurring during, the 1995-97 biennium."

§ 58-21-40. Surplus lines advisory organizations.

(a) A surplus lines advisory organization of surplus lines licensees may be formed to:

(1) Facilitate and encourage compliance by its members with the laws of this State and the rules and regulations of the Commissioner relative to surplus lines insurance;

(2) Communicate with organizations of admitted insurers with respect to the proper use of the surplus lines market; and

(3) Receive and disseminate to its members information relative to surplus lines coverages.

(b) Every such advisory organization shall file with the Commissioner:

(1) A copy of its constitution, articles of agreement or association, or certificate of incorporation;

(2) A copy of its bylaws and rules governing its activities;

(3) A current list of its members;

(4) The name and address of a resident of this State upon whom notices or orders of the Commissioner or processes issued at his direction may be served; and

(5) An agreement that the Commissioner may examine the advisory organization in accordance with the provisions of subsection (c) of this section.

(c) The Commissioner may, at times deemed appropriate, make or cause to be made an examination of each advisory organization; in which case the provisions of G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-150, 58-2-155, 58-2-180, 58-2-185, 58-2-190, 58-2-195, and 58-2-200 shall apply. If the Commissioner finds the advisory organization or any member thereof to be in violation of this Article, the Commissioner may issue an order requiring the discontinuance of the violation.

(d) Each surplus lines licensee shall maintain active membership in an advisory organization as a condition of continued licensure under this Article. (1985, c. 688, s. 1; 1987 (Reg. Sess., 1988), c. 975, s. 13; 1995, c. 193, s. 28.)

Editor's Note. — Session Laws 1995, c. 193, s. 67, contains a severability clause.

ARTICLE 22.

Liability Risk Retention.

§ 58-22-15. Risk retention groups chartered in this State.

(a) A risk retention group seeking to be chartered in this State must be chartered and licensed as a liability insurance company under Article 7 of this Chapter and, except as provided elsewhere in this Article, must comply with all of the laws and rules applicable to such insurers chartered and licensed in this State and with G.S. 58-22-20 to the extent such requirements are not a limitation on laws, administrative rules, or requirements of this State. As a chartered and licensed liability insurance company, the group is subject to the taxes imposed in Article 8B of Chapter 105 of the General Statutes.

(b) Before it may offer insurance in any state, each risk retention group shall also submit for approval to the Commissioner of this State a plan of operation or feasibility study. The risk retention group shall submit an appropriate revision in the event of any subsequent material change in any item of the plan of operation or feasibility study, within 10 days after any such change. The group shall not offer any additional kinds of liability insurance, in this State or in any other state, until a revision of such plan or study is approved by the Commissioner.

(c) At the time of filing its application for a charter, the risk retention group shall provide to the Commissioner in summary form the following information: the identity of the initial members of the group, the identity of those individuals who organized the group or who will provide administrative services or otherwise influence or control the activities of the group, the amount and nature of initial capitalization, the coverages to be afforded, and the states in which the group intends to operate. Upon receipt of this information, the Commissioner shall forward such information to the NAIC. Providing notification to the NAIC is in addition to and shall not be sufficient to satisfy the requirements of G.S. 58-22-20 or any other sections of this Article. (1985 (Reg. Sess., 1986), c. 1013, s. 8; 1987, c. 310, s. 1; c. 727, s. 13; 1993, c. 452, s. 36; 1995 (Reg. Sess., 1996), c. 747, s. 8.)

Editor's Note. — Session Laws 1995 (Reg. Sess., 1996), c. 747, s. 16, provides: "This act does not obligate the General Assembly to appropriate funds."

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective January 1, 1997, added the last sentence in subsection (a).

§ 58-22-20. Risk retention groups not chartered in this State.

Risk retention groups that have been chartered in states other than this State and that seek to do business as risk retention groups in this state must observe and abide by the laws of this State as follows:

(1) Notice of Operations and Designation of Commissioner as Agent. — Before offering insurance in this State, a risk retention group shall submit to the Commissioner:
  a. A statement identifying the state or states in which the risk retention group is chartered and licensed as a liability insurance company, date of chartering, its principal place of business, and such other information including information on its membership, as the Commissioner may require to verify that the risk retention group is qualified under G.S. 58-22-10(10);
  b. A copy of its plan of operations or a feasibility study and revisions of such plan or study submitted to its state of domicile; provided, however, that the provision relating to the submission of a plan of operation or a feasibility study shall not apply with respect to any line or classification of liability insurance that (i) was defined in the Product Liability Risk Retention Act of 1981 before October 27, 1986, and (ii) was offered before that date by any risk retention group that had been chartered and operating for not less than three years before that date;
  c. The risk retention group shall submit a copy of any revision to its plan of operation or feasibility study required by G.S. 58-22-15(b) at the same time that such revision is submitted to the Commissioner of its chartering state; and
  d. A statement of registration that designates the Commissioner as its agent for the purpose of receiving service of legal process.

(2) Financial Condition. — A risk retention group doing business in this State shall file with the Commissioner:
  a. A copy of the group's financial statement submitted to its state of domicile, which shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or a qualified loss reserve specialist, under criteria established by the NAIC or by the Commissioner;
  b. A copy of each examination of the risk retention group as certified by the State insurance regulator or public official conducting the examination;
  c. Upon request by the Commissioner, a copy of any audit performed with respect to the risk retention group; and
  d. Such information as may be required to verify its continuing qualification as a risk retention group under G.S. 58-22-10(10).

(3) Taxation.
  a. All premiums paid for coverages within this State to risk retention groups shall be subject to taxation at the

same rate and subject to the same payment procedures and to the same interest, fines, and penalties for nonpayment as those applicable to surplus lines insurance under Article 21 of this Chapter. Premiums paid by purchasing groups are, however, taxed as provided in G.S. 58-22-35(b).

b. To the extent licensed agents or brokers are utilized pursuant to G.S. 58-22-60, they shall report and pay the taxes for the premiums for risks that they have placed with or on behalf of a risk retention group not chartered in this State. Such agent or broker shall keep a complete and separate record of all policies procured from each such risk retention group, which record shall be open to examination by the Commissioner, as provided in G.S. 58-2-185. These records shall, for each policy and each kind of insurance provided thereunder, include the following:

1. The limit of liability;
2. The time period covered;
3. The effective date;
4. The name of the risk retention group that issued the policy;
5. The gross premium charged; and
6. The amount of return premiums, if any.

c. To the extent that insurance agents or brokers are not utilized or fail to pay the tax, each risk retention group shall pay the tax for risks insured within the State. Each risk retention group shall report to the Commissioner all premiums paid to it for risks insured within the State.

(4) Compliance With Unfair Claims Settlement Practices Law. — A risk retention group and its agents and representatives shall comply with G.S. 58-3-100(5) and G.S. 58-63-15(11).

(5) Deceptive, False, or Fraudulent Practices. — A risk retention group shall comply with the provisions of Article 63 of this Chapter and Chapter 75 of the General Statutes regarding deceptive, false, or fraudulent acts or practices.

(6) Examination Regarding Financial Condition. — A risk retention group must submit to an examination by the Commissioner to determine its financial condition if the insurance regulator of the jurisdiction in which the group is chartered has not initiated an examination or does not initiate an examination within 60 days after a request by the Commissioner. This examination shall be coordinated to avoid unjustified repetition and conducted in an expeditious manner and in accordance with the Examiner Handbook of the NAIC.

(7) Notice to Purchasers. — Any policy issued by a risk retention group shall contain in 10 point type and contrasting color on the front page and the declaration page, the following notice:

"NOTICE

This policy is issued by your risk retention group. Your risk retention group is not subject to all of the insurance laws and regulations of your state. In the event of the insolvency of your risk retention group, losses under this policy will not be paid by any insurance insolvency or guaranty fund in this State."

(8) Prohibited Acts Regarding Solicitation or Sale. — The following acts by a risk retention group are prohibited:

a. The solicitation or sale of insurance by a risk retention group to any person who is not eligible for membership in such group; and

b. The solicitation or sale of insurance by, or operation of, a risk retention group that is in a hazardous financial condition or is financially impaired.

(9) Prohibition of Ownership By An Insurance Company. — No risk retention group shall be allowed to do business in this State if an insurance company is directly or indirectly a member or owner of such risk retention group, other than in the case of a risk retention group all of whose members are insurance companies.

(10) Prohibited Coverage. — No risk retention group may offer insurance policy coverage prohibited or not authorized by this Chapter or declared unlawful by the appellate courts of this State.

(11) Delinquency Proceedings. — A risk retention group not chartered in this State and doing business in this State must comply with a lawful order issued in a voluntary dissolution proceeding or in a delinquency proceeding commenced by a state insurance commissioner if there has been a finding of financial impairment after an examination under G.S. 58-22-20(6).

(12) Penalties. — A risk retention group that violates any provision of this Article is subject to G.S. 58-2-70. (1985 (Reg. Sess., 1986), c. 1013, s. 8; 1987, c. 310, s. 1; c. 727, ss. 1, 2; 1993, c. 452, s. 37; 1995 (Reg. Sess., 1996), c. 747, s. 9.)

Editor's Note. — Session Laws 1995 (Reg. Sess., 1996), c. 747, s. 16, provides: "This act does not obligate the General Assembly to appropriate funds."

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective January 1, 1997, added the last sentence in subdivision (3)a.

§ 58-22-35. Purchasing groups; exemption from certain laws relating to the group purchase of insurance.

(a) Any purchasing group meeting the criteria established under the provisions of 15 U.S.C. § 3901 et seq. is exempt from any law of this State relating to the creation of groups for the purchase of insurance, prohibition of group purchasing, or any law that discriminates against a purchasing group or its members. In addition, an insurer is exempt from any law of this State that prohibits providing, or offering to provide, to a purchasing group or its members, advantages based on their loss and expense experience not afforded to other persons with respect to rates, policy forms, coverages, or other matters. A purchasing group is subject to all other applicable laws of this State.

(b) Taxes on premiums paid for coverage of risks resident or located in this State by a purchasing group or any members of the purchasing group shall be:

(1) Imposed at the same rate and subject to the same interest, fines, and penalties as those applicable to premium taxes on similar coverage from a similar insurance source by other insureds. For example, coverage provided by a surplus lines licensee is taxed under Article 21 of this Chapter, coverage provided by an insurance company is taxed under Article 8B of Chapter 105 of the General Statutes, and coverage provided by an unlicensed insurer is taxed under G.S. 58-28-5(b).

(2) Paid first by such insurance source, and if not by such source then by the agent or broker for the purchasing group, and if not by such agent or broker then by the purchasing group, and if not by such group then by each of its members. (1987, c. 310, s. 1; c. 727, s. 9; 1995 (Reg. Sess., 1996), c. 747, s. 10.)

Editor's Note. — Session Laws 1995 (Reg. Sess., 1996), c. 747, s. 16, provides: "This act does not obligate the General Assembly to appropriate funds."

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective January 1, 1997, in subdivision (b)(1), deleted "and" following "by other insureds" in the first sentence, added the second sentence, and made a punctuation change.

§ 58-22-70. Registration and renewal fees.

Editor's Note. —

Session Laws 1995, c. 507, s. 11A(c), amended Session Laws 1989 (Reg. Sess., 1990), c. 1069, s. 31, deleting the last sentence regarding the expiration of amendments to the General Statutes by Session Laws 1989 (Reg. Sess., 1990), c. 1069, if the legislature did not appropriate or transfer funds. Session Laws 1989 (Reg. Sess., 1990), s. 31, as amended by Session Laws 1995, c. 507, s. 11A(c), provides: "Section 23 [see § 58-36-70] of this act does not apply to the 1990 automobile rate filing made pursuant to Article 36 of Chapter 58 of the General Statutes. Section 27 [§ 143-3.6] of this act shall expire at the end of the 1993-1994 fiscal year and Section 28 [§ 143-3.7] shall become effective upon the expiration of Section 27."

Session Laws 1995, c. 507, s. 1.1, provides that that act shall be known and cited as the Expansion and Capital Improvements Appropriations Act of 1995.

Session Laws 1995, c. 507, s. 28.9, provides: "Except for statutory changes or other provisions that clearly indicate an intention to have effects beyond the 1995-97 fiscal biennium, the textual provisions of this act apply only to funds appropriated for, and activities occurring during, the 1995-97 biennium."

Article 23.

Local Government Risk Pools.

§ 58-23-1. Short title; definition.

CASE NOTES

Board of Education could not join a risk pool pursuant to this section. Lyles v. City of Charlotte, 344 N.C. 676, 477 S.E.2d 150 (1996).

Counties, Cities, and Housing Authorities. — Only counties, cities, and housing authorities are defined as local governments for purposes of joining a local government risk pool. Lyles v. City of Charlotte, 344 N.C. 676, 477 S.E.2d 150 (1996).

§ 58-23-5. Local government pooling of property, liability and workers' compensation coverages.

CASE NOTES

Risk management program in which city participated fell within the scope of the statute. Lyles v. City of Charlotte, 120 N.C. App. 96, 461 S.E.2d 347 (1995).

Counties, Cities, and Housing Authorities. — Only counties, cities, and housing authorities are defined as local governments for purposes of joining a local government risk pool. Lyles v. City of Charlotte, 344 N.C. 676, 477 S.E.2d 150 (1996).

Claim Not Paid If Reimbursed. — A local government risk pool agreement must contain a provision that the pool pay all claims for which a member incurs liability; the pool has not paid a claim if it is reimbursed for it. Lyles v. City of Charlotte, 344 N.C. 676, 477 S.E.2d 150 (1996).

The risks of the parties must be put in one pool for the payment of claims in order to have a local government risk pool. Lyles v. City of Charlotte, 344 N.C. 676, 477 S.E.2d 150 (1996).

§ 58-23-10. Board of trustees.

CASE NOTES

Cited in Lyles v. City of Charlotte, 344 N.C. 676, 477 S.E.2d 150 (1996).

§ 58-23-15. Contract.

CASE NOTES

The risks of the parties must be put in one pool for the payment of claims in order to have a local government risk pool. Lyles v. City of Charlotte, 344 N.C. 676, 477 S.E.2d 150 (1996).

ARTICLE 24.

Fraternal Benefit Societies.

§ 58-24-100. Investments.

A society shall invest its funds only in investments that are authorized by the laws of this State for the investment of assets of life insurers and subject to the limitations thereon. Any foreign or alien society permitted or seeking to do business in this State must comply in substance with the investment requirements and limitations imposed by Article 7 of this Chapter and applicable to life insurers; provided, that any society that invests its funds in accordance with the laws of the state, district, territory, country, or province in which it is incorporated, shall thereby be deemed to be in compliance with the investment requirements and limitations for a period of two years from January 1, 1988. (1987, c. 483, s. 2; 1995, c. 193, s. 29.)

Editor's Note. — Session Laws 1995, c. 193, s. 67, contains a severability clause.

§ 58-24-135. Examination of societies; no adverse publications.

(a) The Commissioner, or any person he or she may appoint, may examine any domestic, foreign or alien society transacting or applying for admission to transact business in this State in the same manner as authorized for examination of domestic, foreign or alien insurers. Requirements of notice and an opportunity to respond before findings are made public as provided in the laws regulating insurers shall also be applicable to the examination of societies.

(b) Repealed by Session Laws 1995, c. 360, s. 2(i), effective July 1, 1995. (1987, c. 483, s. 2; 1991, c. 720, s. 4; 1995, c. 360, s. 2(i).)

Editor's Note. — This section is set out in the form above at the direction of the Revisor of Statutes.

ARTICLE 28.

Unauthorized Insurers.

§ 58-28-5. Transacting business without certificate of authority prohibited; exceptions.

(a) Except as hereinafter provided, it shall be unlawful for any company to enter into a contract of insurance as an insurer or to transact insurance business in this State as set forth in G.S. 58-28-10, without a certificate of authority issued by the Commissioner. This section shall not apply to the following acts or transactions:

(1) The procuring of a policy of insurance upon a risk within this State where the applicant is unable to procure coverage in the open market with admitted companies and is otherwise in compliance with Article 21 of this Chapter;

(2) Contracts of reinsurance; but not including assumption reinsurance transactions, whereby the reinsuring company succeeds to all of the liabilities of and supplants the ceding company on the insurance contracts that are the subject of the transaction, unless prior approval has been obtained from the Commissioner;

(3) Transactions in this State involving a policy lawfully solicited, written and delivered outside of this State covering only subjects of insurance not resident, located or expressly to be performed in this State at the time of issuance, and which transactions are subsequent to the issuance of such policy;

(4) Transactions in this State involving group life insurance, group annuities, or group, blanket, or franchise accident

and health insurance where the master policy of such insurance was lawfully issued and delivered in a state where the company was authorized to transact business;

(5) Transactions in this State involving all policies of insurance issued prior to July 1, 1967;

(6) The procuring of contracts of insurance issued to a nuclear insured;

(7) Insurance independently procured, as specified in subsection (b) of this section;

(8) Insurance on vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine insurance policies, as distinguished from inland marine insurance policies.

(b) Any person in this State may directly procure or directly renew insurance with an unlicensed insurer without the involvement of an agent, broker, or surplus lines licensee, on a risk located or to be performed, in whole or in part, in this State. The person shall, within 30 days after the date the insurance is procured or renewed, file a written report with the Commissioner on forms prescribed by the Commissioner. The report must contain the name and address of the insured; name and address of the insurer; the subject of insurance; a general description of the coverage; the amount of premium currently charged; and any additional information requested by the Commissioner. The report must also contain an affidavit of the insured that states that the full amount or kind of insurance cannot be obtained from insurers that are admitted to do business in this State; and that the insured has made a diligent search among the insurers that are admitted to transact and are actually writing the particular kind and class of insurance in this State. Gross premiums charged for the insurance, less any return premiums, are subject to a tax at the rate of five percent (5%). At the time of filing the report required by this subsection, the insured shall pay the tax to the Commissioner. The Commissioner has the powers specified in G.S. 58-21-90 with respect to the tax levied by this subsection.

(c) This section does not apply to any surviving nonprofit corporation that results from a merger between the nonprofit corporation established by the North Carolina State Bar Council pursuant to Chapter 707 of the 1975 Session Laws of North Carolina and another domestic nonprofit corporation; provided, however, that any such surviving corporation shall register with the North Carolina State Bar Council under G.S. 84-23.1. (1967, c. 909, s. 1; 1971, c. 510, s. 3; 1985, c. 688, s. 2; 1987, c. 727, ss. 4, 5; c. 864, ss. 47, 70; 1991, c. 644, s. 6; 1993, c. 409, s. 26; c. 504, s. 20; 1995, c. 193, s. 30.)

Editor's Note. — Session Laws 1995, c. 193, s. 67, contains a severability clause.

ARTICLE 30.

Insurers Supervision, Rehabilitation, and Liquidation.

§ 58-30-5. Persons covered.

The proceedings authorized by this Article may be applied to:

(1) All insurers who are doing, or have done, an insurance business in this State, and against whom claims arising from that business may exist now or in the future.

(2) All insurers who purport to do an insurance business in this State.

(3) All insurers who have insureds resident in this State.

(4) All persons organized or in the process of organizing with the intent to do an insurance business in this State.

(5) All persons subject to Articles 64, 65 and 66, or 67 of this Chapter; except to the extent there is a conflict between the provisions of this Article and the provisions of those Articles, in which case those Articles will govern.

(6) Self-insured group workers' compensation funds organized under G.S. 97-93(a)(2). (1989, c. 452, s. 1; 1995, c. 471, s. 3; 1995 (Reg. Sess., 1996), c. 582, s. 1.)

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective October 1, 1996, and applicable to continuing care retirement centers that are determined by the Commissioner of Insurance to be financially impaired on or after that date, substituted "Articles 64, 65 and 66, or 67" for "Articles 65 through 67" in subdivision (5).

§ 58-30-10. Definitions.

As used in this Article, unless the context clearly indicates otherwise:

(1) "Alien country" means any other jurisdiction not in any state.

(2) "Ancillary state" means any state other than a domiciliary state.

(3) "Court" means the Superior Court of Wake County.

(4) "Creditor" means a person having any claim, whether matured or unmatured, liquidated or unliquidated, secured or unsecured, absolute, fixed, or contingent.

(5) "Delinquency proceeding" means any proceeding instituted against an insurer for the purpose of supervising, rehabilitating, conserving, or liquidating such insurer.

(6) "Doing business" includes any of the following acts by insurers, whether effected by mail or otherwise:

  a. The issuance or delivery of contracts of insurance to persons resident in this State;

  b. The solicitation of applications for such contracts, or other negotiations preliminary to the execution of such contracts;

  c. The collection of premiums, membership fees, assessments, or other consideration for such contracts;

  d. The transaction of matters subsequent to execution of such contracts and arising out of them;

  e. Operating as an insurer under a license or certificate of authority issued by the Department; or

f. The purchase of contracts of insurance issued to persons in this State by an assumption agreement.

(7) "Domestic guaranty association" means the Postassessment Insurance Guaranty Association in Article 48 of this Chapter, as amended; the North Carolina Self-Insurance Guaranty Association in Article 4 of Chapter 97 of the General Statutes; the Life and Accident and Health Insurance Guaranty Association in Article 62 of this Chapter, as amended; or any other similar entity hereafter created by the General Assembly for the payment of claims of insolvent insurers.

(8) "Domiciliary state" means the state in which an insurer is incorporated or organized; or, in the case of an alien insurer, its state of entry.

(9) "Fair consideration" is given for property or obligation when:

a. In exchange for such property or obligation, as a fair equivalent therefor, and in good faith, property is conveyed or services are rendered or an obligation is incurred or an antecedent debt is satisfied; or

b. Such property or obligation is received in good faith to secure a present advance or antecedent debt in amount not disproportionately small as compared to the value of the property or obligation obtained.

(10) "Foreign guaranty association" means a guaranty association now in existence in or hereafter created by the legislature of any other state.

(11) "Formal delinquency proceeding" means any liquidation or rehabilitation proceeding.

(12) "General assets" means all real, personal, or other property that is not specifically mortgaged, pledged, hypothecated, deposited, or otherwise encumbered for the security or benefit of specified persons or classes of persons. As to specifically encumbered property, "general assets" includes all such property or its proceeds in excess of the amount necessary to discharge the sum or sums secured thereby. Assets that are held in trust and on deposit for the security or benefit of all policyholders in more than one state or all policyholders and creditors in more than one state shall be treated as "general assets".

(13) "Insolvency" or "insolvent" means that an insurer is unable to pay its obligations when they are due, or that its admitted assets do not exceed its liabilities plus the greater of (i) any capital and surplus required by law for its organization; or (ii) the total par or stated value of its authorized and issued capital stock. For the purposes of this subdivision, "liabilities" includes reserves required by statute, by Department rules, or by specific requirements imposed by the Commissioner upon a subject company at the time of admission or subsequent thereto, except those reserves that are an allocation of surplus as specified in G.S. 58-65-95.

(14) "Insurer" means any entity licensed under Articles 7, 16, 26, 49, 65, or 67 of this Chapter and any employer that has furnished to the Commissioner satisfactory proof of its financial responsibility under G.S. 97-93(a)(2). For pur-

poses of this Article, "insurer" also includes continuing care retirement centers licensed under Article 64 of this Chapter.

(15) "Preferred claim" means any claim with respect to which the provisions of this Article accord priority of payment from the general assets of the insurer.

(16) "Receiver" includes a liquidator, rehabilitator, or conservator, as the context requires.

(17) "Reciprocal state" means any state other than this State in which in substance and effect the provisions of G.S. 58-30-105(a), 58-30-270, 58-30-275, and 58-30-285 through 58-30-295 are in force, and in which provisions are in force requiring that the insurance regulator of that state be the receiver of a delinquent insurer; and in which provisions exist for the avoidance of fraudulent conveyances and preferential transfers.

(18) "Secured claim" means any claim secured by mortgage, trust deed, pledge, deposit as security, escrow, or otherwise; and includes any claim that has become a lien upon specific assets by reason of judicial process. "Secured claim" does not include a special deposit claim or a claim against general assets.

(19) "Special deposit claim" means any claim secured by a deposit made pursuant to statute for the security or benefit of a limited class or classes of persons, but does not include any claim secured by general assets.

(20) "Transfer" includes the sale and every other and different mode, whether direct or indirect, of disposing of or of parting with property, an interest therein, or the possession thereof; or of voluntarily fixing a lien upon property or an interest therein, whether absolutely or conditionally, by or without judicial proceedings. The retention of a security title to property delivered to a debtor is a transfer suffered by the debtor. (1989, c. 452, s. 1; 1995, c. 471, ss. 4, 5; 1995 (Reg. Sess., 1996), c. 582, s. 2; c. 742, s. 24.)

Effect of Amendments. — Session Laws 1995 (Reg. Sess., 1996), c. 582, s. 2, effective October 1, 1996, and applicable to continuing care retirement centers that are determined by the Commissioner of Insurance to be financially impaired on or after that date, in subdivision (14), inserted "49", and added the last sentence.

Session Laws 1995 (Reg. Sess., 1996), c. 742, s. 24, effective June 21, 1996, deleted "the" preceding "the North Carolina Self-Insurance Guaranty Association" in subdivision (7).

§ 58-30-20. Injunctions and orders.

CASE NOTES

The Commissioner as liquidator is entitled to seek an injunction when necessary to prevent the withholding of all documents and records related to the business of the insurer. Eastern Appraisal Servs., Inc. v. State, 118 N.C. App. 692, 457 S.E.2d 312, appeal dismissed, cert. denied, 341 N.C. 648, 462 S.E.2d 509 (1995).

§ 58-30-22. Powers of Commissioner and receiver to examine or audit books or records.

(a) As used in this section, "person" includes an agent of the insurer; a broker, ceding or assuming reinsurer, or reinsurance intermediary that has done business with the insurer; or any affiliate of the insurer.

(b) In addition to other powers granted under this Chapter, the Commissioner in any supervision proceeding under this Article and a receiver in any delinquency proceeding under this Article has the power to examine or audit the books or records of any person insofar as those books or records relate to the business activities of the insurer that is under supervision or subject to a delinquency proceeding.

(c) Repealed by Session Laws 1995, c. 360, s. 2(a), effective July 1, 1995. (1991, c. 681, s. 42; 1995, c. 360, s. 2(a).)

§ 58-30-25. Cooperation of officers, owners and employees.

CASE NOTES

Quoted in Eastern Appraisal Servs., Inc. v. State, 118 N.C. App. 692, 457 S.E.2d 312 (1995).

§ 58-30-75. Grounds for rehabilitation.

The Commissioner may petition the Court for an order authorizing him to rehabilitate a domestic insurer or an alien insurer domiciled in this State on any one or more of the following grounds:

(1) The insurer is in such condition that the further transaction of business would be hazardous financially to its policyholders, creditors, or the public.

(2) There is reasonable cause to believe that there has been embezzlement from the insurer, wrongful sequestration or diversion of the insurer's assets, forgery or fraud affecting the insurer, or other illegal conduct in, by, or with respect to the insurer that if established would endanger assets in an amount threatening the solvency of the insurer.

(3) The insurer has failed to remove any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, employee, or other person; if the person has been found after notice and hearing by the Commissioner to be dishonest or untrustworthy in a way affecting the insurer's business.

(4) Control of the insurer, whether by stock ownership or otherwise, and whether direct or indirect, is in a person or persons found after notice and hearing to be untrustworthy.

(5) Any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, director or trustee, employee, or other person, has refused to be examined under oath by the Commissioner concerning its affairs, whether in this State or elsewhere; and after reasonable notice of the fact, the insurer has failed

promptly and effectively to terminate the employment and status of the person and all his influence on management.

(6) After demand by the Commissioner the insurer has failed to promptly make available for examination any of its own property, books, accounts, documents, or other records; those of any subsidiary or related company within the control of the insurer; or those of any person having executive authority in the insurer insofar as they pertain to the insurer.

(7) Without first obtaining the written consent of the Commissioner pursuant to G.S. 58-7-150, the insurer has (i) transferred, or attempted to transfer, in a manner contrary to Article 19 of this Chapter, substantially its entire property or business, or (ii) has entered into any transaction, the effect of which is to merge, consolidate, or reinsure substantially its entire property or business in or with the property or business of any other person.

(8) The insurer or its property has been or is the subject of an application for the appointment of a receiver, trustee, custodian, conservator, or sequestrator or similar fiduciary of the insurer or its property otherwise than as authorized under Articles 1 through 64 of this Chapter, and such appointment has been made or is imminent, and such appointment might oust the courts of this State of jurisdiction or might prejudice orderly delinquency proceedings under this Article.

(9) Within the previous four years the insurer has willfully violated its charter or articles of incorporation, its bylaws, Articles 1 through 67 of this Chapter, or any valid order of the Commissioner under G.S. 58-30-60.

(10) The insurer has failed to pay within 60 days after due any obligation to any state or any subdivision thereof or any judgment entered in any state, if the court in which such judgment was entered has jurisdiction over such subject matter; except that such nonpayment is not a ground until 60 days after any good faith effort by the insurer to contest the obligation has been terminated, whether it is before the Commissioner or in the courts, or the insurer has systematically attempted to compromise or renegotiate previously agreed settlements with its creditors on the ground that it is financially unable to pay its obligations in full.

(11) The insurer has failed to file its annual report or any other financial report required by statute within the time allowed by law and, after written demand by the Commissioner, has failed to immediately give an adequate explanation.

(12) The board of directors or the holders of a majority of the shares entitled to vote, or a majority of those individuals entitled to the control of those persons specified in G.S. 58-30-5, request or consent to rehabilitation under this Article. (1989, c. 452, s. 1; c. 770, s. 72.1; 1995, c. 193, s. 31.)

Editor's Note. —
Session Laws 1995, c. 193, s. 67, contains a severability clause.

§ 58-30-160. Setoffs.

(a) Mutual debts or mutual credits, whether arising out of one or more contracts between the insurer and another person in connection with any action or proceeding under this Article shall be set off and the balance only shall be allowed or paid, except as provided in subsections (b), (d), and (e) of this section and in G.S. 58-30-175.

(b) No setoff shall be allowed in favor of any person where:

(1) The obligation of the insurer to the person would not at the date of the filing of a petition for liquidation entitle the person to share as a claimant in the assets of the insurer;

(2) The obligation of the insurer to the person was purchased by or transferred to the person with a view to its being used as a setoff;

(3) The obligation of the person is to pay an assessment levied against the members or subscribers of the insurer, or is to pay a balance upon a subscription to the capital stock of the insurer, or is in any other way in the nature of a capital contribution;

(4) Repealed by Session Laws 1995 (Regular Session, 1996), c. 658, s. 1, effective October 1, 1996.

(5) The obligation of the insurer is owed to an affiliate of the person, or to any other entity or association other than the person;

(6) The obligation of the person is owed to an affiliate of the insurer, or to any other entity or association other than the insurer;

(7) The obligations between the person and the insurer arise out of transactions where either the person or the insurer has assumed risks and obligations from the other party and then has ceded back to that party substantially the same risks and obligations;

(8) The obligation of the person is to pay to the insurer sums held in a fiduciary capacity for the insurer; or

(9) The person alone or together with any other member of its insurance company holding system owns fifty percent (50%) or more of the voting stock of the insurer.

(c) A setoff shall be permitted to local agents against agents' balances otherwise payable to the domiciliary or ancillary receiver for the amount expended by the agents to replace insurance coverage of their insureds and the reasonable expenses incident thereto as a result of any domestic, foreign or alien insurer being placed in delinquency proceedings. Agents claiming a setoff shall within 60 days of replacing coverage provide a verified accounting of the replacement of the insurance to the domiciliary receiver, the ancillary receiver, if any, and the North Carolina Insurance Guaranty Association or similar organization in the state of residence of the policyholder. The verified accounting shall include the name of the agent, the name of the insured, the policy number, the replacement policy number, the cost of the replacement policy, the amount of unearned premium under each policy as to which setoff is claimed, any claimed expenses and a verification that the accounting has been provided to each of the persons and entities described herein. Unearned premiums set off as provided above in any amount shall be deemed paid in full by the insurer and no person shall have a claim for the unearned premiums against the North Carolina

Insurance Guaranty Association or similar organization in the state of residence of the policyholder.

(d) The receiver shall provide persons with accounting statements identifying debts which are currently due and payable. Where a person owes to the insurer currently due and payable balances, against which the person asserts setoff of mutual credits which may become due and payable from the insurer in the future, the person shall promptly pay to the receiver the currently due and payable amount; provided that, notwithstanding any other provision of this Article, the receiver shall promptly and fully refund, to the extent of the person's prior payments, any mutual credits that become due and payable to the person by the insurer.

(e) Notwithstanding any other provision of this section, a setoff of sums due on obligations in the nature of those set forth in subdivision (b)(7) of this section shall be allowed for those sums accruing from business written where the contracts were entered into, renewed, or extended with the express written approval of the insurance regulator of the state of domicile of the now insolvent insurer, when in the judgment of the regulator it was necessary to provide reinsurance in order to prevent or mitigate a threatened impairment or insolvency of the insurer in connection with the exercise of the regulator's official responsibilities. (1989, c. 452, s. 1; 1991, c. 681, s. 47; 1995 (Reg. Sess., 1996), c. 658, s. 1.)

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective October 1, 1996, repealed subdivision (b)(4), which read "The obligation of the person is to pay earned premiums to the insurer."

§ 58-30-180. Domiciliary liquidator's proposal to distribute assets.

(a) Within 120 days of a final determination of insolvency of an insurer by the Court, the liquidator shall make application to the Court for approval of a proposal to disburse assets out of marshalled assets, from time to time as such assets become available, to a domestic or foreign guaranty association having obligations because of such insolvency. If the liquidator determines that there are insufficient assets to disburse, the application required by this section shall be considered satisfied by a filing by the liquidator stating the reasons for this determination.

(b) Such proposal shall at least include provisions for:

(1) Reserving amounts for the payment of expenses of administration and the payment of claims of secured creditors, to the extent of the value of the security held, and claims falling within the priorities established in G.S. 58-30-220(1) and (4);

(2) Disbursement of the assets marshalled to date and subsequent disbursement of assets as they become available;

(3) Equitable allocation of disbursements to each of the domestic and foreign guaranty associations entitled thereto;

(4) The securing by the liquidator from each of the associations entitled to disbursements pursuant to this section of an agreement to return to the liquidator such assets, together with income earned on assets previously disbursed, as may be required to pay claims of secured creditors and claims falling within the priorities established in G.S. 58-30-220 in

accordance with such priorities. No bond shall be required of any such association; and

(5) A full report to be made by each association to the liquidator accounting for all assets so disbursed to the association, all disbursements made therefrom, any interest earned by the association on such assets and any other matter as the Court directs.

(c) The liquidator's proposal shall provide for disbursements to the associations in amounts estimated at least equal to the claim payments made or to be made thereby for which such associations could assert a claim against the liquidator; and shall further provide that if the assets available for disbursement from time to time do not equal or exceed the amount of such claim payments made or to be made by the association then disbursements shall be in the amount of available assets.

(d) The liquidator's proposal shall, with respect to an insolvent insurer writing life or health insurance or annuities, provide for disbursements of assets to any domestic or foreign guaranty association covering life or health insurance or annuities or to any other entity reinsuring, assuming, or guaranteeing policies or contracts of insurance under the acts creating such associations.

(e) Notice of such application shall be given to the association in and to the insurance regulators of each of the states. Any such notice shall be deemed to have been given when deposited in United States certified mail, first class postage prepaid, at least 30 days prior to submission of such application to the Court. Action on the application may be taken by the Court provided the above required notice has been given and provided further that the liquidator's proposal complies with subdivisions (b)(1) and (b)(2) of this section. (1989, c. 452, s. 1; 1995, c. 517, s. 13.)

Editor's Note. — Session Laws 1995, c. 517, s. 41, contains a severability clause.

§ 58-30-220. Priority of distribution.

The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is set forth in this section. Every claim in each class shall be paid in full or adequate funds shall be retained for payment before the members of the next class receive any payment. No subcategories shall be established within the categories in a class. The order of distribution of claims shall be:

(1) The receiver's expenses for the administration and conservation of assets of the insurer.

(2) Claims or portions of claims for benefits under policies and for losses incurred, including claims of third parties under liability policies; claims for unearned premiums; claims for funds or consideration held under funding agreements, as defined in G.S. 58-7-16; claims under life insurance and annuity policies, whether for death proceeds, annuity proceeds, or investment values; and claims of domestic and foreign guaranty associations, including claims for the reasonable administrative expenses of domestic and foreign guaranty associations; but excluding claims of insurance pools, underwriting associations, or those arising out

of reinsurance agreements, claims of other insurers for subrogation, and claims of insurers for payments and settlements under uninsured and underinsured motorist coverages.

(3) Claims of the federal or any state or local government or taxing authority, including claims for taxes.

(4) Compensation actually owing to employees other than officers of the insurer for services rendered within three months before the commencement of a delinquency proceeding against the insurer under this Article, but not exceeding one thousand dollars ($1,000) for each employee. In the discretion of the Commissioner, this compensation may be paid as soon as practicable after the proceeding has been commenced. This priority is in lieu of any other similar priority that may be authorized by law as to wages or compensation of those employees.

(5) Claims of general creditors, including claims of insurance pools, underwriting associations, or those arising out of reinsurance agreements; claims of other insurers for subrogation; and claims of insurers for payments and settlements under uninsured and underinsured motorist coverages. (1989, c. 452, s. 1; 1993 (Reg. Sess., 1994), c. 600, s. 2; 1995, c. 517, s. 14.)

Editor's Note. — Session Laws 1995, c. 517, s. 41, contains a severability clause.

CASE NOTES

Common Fund Doctrine Precluded. — The comprehensive nature of this section precludes the application of any equitable doctrine — including the common fund doctrine — to alter the Class 5 priority assigned to attorneys' claims for fees in insurance company liquidation. State ex rel. Long v. Interstate Cas. Ins. Guar. Ass'n, 120 N.C. App. 743, 464 S.E.2d 73 (1995).

Assets Must Be Part of the Insurer's Estate. — "Assets," as used in subsection (1), must refer to items listed by the liquidator which become part of the "insurer's estate." Class 1 priority, therefore, is awarded only to entities which conserve or administer assets of the insurer after the items have become part of the "insurer's estate." State ex rel. Long v. Interstate Cas. Ins. Guar. Ass'n, 120 N.C. App. 743, 464 S.E.2d 73 (1995).

§ 58-30-225. Liquidator's recommendations to the Court.

CASE NOTES

Because of the discretionary nature of subsection (b), the trial court's decision regarding priority should not be disturbed absent an abuse of discretion. State ex rel. Long v. Interstate Cas. Ins. Guar. Ass'n, 120 N.C. App. 743, 464 S.E.2d 73 (1995).

§ 58-30-300. Interstate priorities.

(a) In a liquidation proceeding in this State involving one or more reciprocal states, the order of distribution of the domiciliary state shall control as to all claims of residents of this and reciprocal states. All claims of residents of reciprocal states shall be given equal priority of payment from general assets regardless of where such assets are located.

(b) The owners of special deposit claims against an insurer for which a liquidator is appointed in this or any other state shall be given priority against the special deposits in accordance with the statutes governing the creation and maintenance of the deposits. If there is a deficiency in any deposit, so that the claims secured by it are not fully discharged from it, the claimants may share in the general assets, but the sharing shall be deferred until general creditors, and also claimants against other special deposits who have received smaller percentages from their respective special deposits, have been paid percentages of their claims equal to the percentage paid from the special deposit.

(c) The owner of a secured claim against an insurer for which a liquidator has been appointed in this or any other state may surrender the owner's security and file the claim as a general creditor, or the claim may be discharged by resort to the security in accordance with G.S. 58-30-215 in which case the deficiency, if any, shall be treated as a claim against the general assets of the insurer on the same basis as claims of unsecured creditors. (1989, c. 452, s. 1; 1995, c. 193, s. 32.)

Editor's Note. — Session Laws 1995, c. 193, s. 67, contains a severability clause.

ARTICLE 31.

Insuring State Property, Officials and Employees.

§ 58-31-5. Appropriations; fund to pay administrative expenses.

Upon the expiration of the existing fire insurance policies on said properties and in making appropriations for any biennium after the next biennium, the Commissioner shall file with the Department of Administration his estimate of the appropriations which will be necessary in order to set up and maintain an adequate reserve to provide a fund sufficient to protect the State, its departments, institutions, and agencies from loss or damage to any of said properties up to fifty per centum (50%) of the value thereof. Appropriations made for the creating of such fire insurance reserves against property of the Department of Agriculture and Consumer Services, or the Department of Transportation or any special operating fund shall be charged against the funds of such departments.

The State Property Fire Insurance Fund is authorized and empowered to pay all the administrative expenses occasioned by the administration of Article 31 of Chapter 58 of the General Statutes. (1945, c. 1027, s. 2; 1957, c. 65, s. 11; c. 269, s. 1; 1959, c. 182, s. 1; 1973, c. 507, s. 5; 1977, c. 464, s. 34; 1991, c. 720, s. 4; 1997-261, s. 109.)

Effect of Amendments. — The 1997 amendment, effective July 1, 1997, substituted "Department of Agriculture and Consumer Services" for "Department of Agriculture".

§ 58-31-52. State motor vehicle safety program.

(a) Findings, Policy, and Purpose. — Motor vehicle accidents exact a terrible toll of human tragedy and suffering as well as national resources within the United States. The same is true, on a smaller scale, within North Carolina State government. Every year State employees or members of the general public are killed or injured, and a significant portion of the State's financial resources is expended as a direct result of accidents involving State-owned vehicles. Accordingly, it is North Carolina policy that the State-owned motor vehicle fleet and vehicles used on behalf of the State be operated and maintained in such a manner as to minimize deaths, injuries, and costs. The purpose of this section is to direct the Commissioner of Insurance to develop a program to provide policy, requirements, procedures, technical information, and standards for administering a State vehicle safety program which will apply to all State personnel involved in the administration and operation of vehicles on behalf of the State.

(b) The Commissioner shall develop and adopt a State motor vehicle safety program to assure that State-owned motor vehicles are operated and maintained in a safe manner.

(c) In developing the program, the Commissioner shall include the following:

(1) Basic criteria concerning qualifications, screening, and education of drivers.
(2) Required and prohibited driving practices.
(3) Safety maintenance requirements.
(4) Accident reporting and review procedures.

(d) The requirements and procedures established under the program apply to all agencies and persons operating vehicles on behalf of the State, unless specifically exempted by the Commissioner. Agencies may adopt more stringent requirements and procedures than those adopted by the Commissioner under this section. The administration of the program in each agency is the responsibility of each agency head or that person's designee.

(e) The provisions of Chapter 150B of the General Statutes do not apply to the program developed and adopted under this section. (1995, c. 517, s. 15.)

Editor's Note. — Session Laws 1995, c. 517, s. 42, made this section effective upon ratification. The act was ratified July 29, 1995.

Session Laws 1995, c. 517, s. 41, contains a severability clause.

§ 58-31-60. Competitive selection of payroll deduction insurance products paid for by State employees.

(a) Employee Insurance Committee. — The head of each State government employee payroll unit offering payroll deduction insurance products to employees shall appoint an Employee Insurance Committee for the following purposes:

(1) To review insurance products currently offered through payroll deduction to the State employees in the Employee Insurance Committee's payroll unit to determine if those products meet the needs and desires of employees in the Employee Insurance Committee's payroll unit.

(2) To select the types of insurance products that reflect the needs and desires of employees in the Employee Insurance Committee's payroll unit.

(3) To competitively select the best insurance products of the types determined by the Employee Insurance Committee to reflect the needs and desires of the employees of that payroll unit.

As used in this section, "insurance product" includes a prepaid legal services plan registered under G.S. 84-23.1.

(b) Appointment of Employee Insurance Committee Members. — The members of the Employee Insurance Committee shall be appointed by the head of the payroll unit. The Committee shall consist of not less than five or more than nine individuals a majority of whom have been employed in the payroll unit for at least one year. The committee members shall, except where necessary initially to establish the rotation herein prescribed, serve three-year terms with approximately one-third of the terms expiring annually. Committee membership make-up shall fairly represent the work force in the payroll unit and be selected without regard to any political or other affiliations. It shall be the duty of the payroll unit head to assure that the Employee Insurance Committee is completely autonomous in its selection of insurance products and insurance companies and that no member of the Employee Insurance Committee has any conflict of interest in serving on the Committee. A committee on employee benefits elected or appointed by the faculty representative body of a constituent institution of The University of North Carolina shall be deemed constituted and functioning as an employee insurance committee in accordance with this section. Any decision rendered by the Employee Insurance Committee where the autonomy of the Committee or a conflict of interest is questioned shall be subject to appeal pursuant to the Administrative Procedure Act, or in the case of departments, boards and commissions which are specifically exempt from the Administrative Procedure Act, pursuant to the appeals procedure prescribed for such department, board or commission.

All payroll units in existence on May 21, 1985, shall continue to be deemed payroll units, regardless of any subsequent consolidation of such payroll units, for purposes of the appointment of the members of the Employee Insurance Committee in order to assure such units the continuing ability to meet the needs and desires of the employees of such units by having the right to select insurance carriers and insurance products. No Employee Insurance Committee shall be created for employees represented by a previously existing committee. Any such duplicative Employee Insurance Committees are hereby disbanded. In the event of the consolidation of a payroll unit, the head of the former payroll unit shall appoint the members of the Committee in accordance with the provisions of this section.

(c) Payroll Deduction Slots. — Each payroll unit shall be entitled to not less than four payroll deduction slots to be used for payment of insurance premiums for products selected by the Employee Insurance Committee and offered to the employees of the payroll unit. The Employee Insurance Committee shall select only one company per payroll deduction slot. The Company selected by the Employee Insurance Committee shall be permitted to sell through payroll deduction only the products specifically approved by the Employee Insurance Committee. The assignment by the Employee Insurance Committee of a payroll deduction slot shall be for a period of not less than two years unless the insurance company shall be in violation of the terms of the written agreement specified in this subsection. The insurance company awarded a payroll deduction slot shall, pursuant to a written agreement setting out the rights and duties of the insurance company, be afforded an adequate opportunity to solicit employees of the payroll unit by making such employees aware that a representative of the company will be available at a specified time and at a location convenient to the employees.

Notwithstanding any other provision of the General Statutes, once an employee has selected an insurance product for payroll deduction, that product may not be removed from payroll deduction for that employee without his or her specific written consent.

When an employee retires from State employment and payroll deduction under this section is no longer available, the insurance company may not terminate life insurance products purchased under the payroll deduction plan without the retiree's specific written consent solely because the premium is no longer deducted from payroll.

(c1) Procedure for Selection of Insurance Product Proposals. — All insurance product proposals shall be sealed. The Committee shall open all proposals in public and record them in the minutes of the Committee, at which time the proposals become public records open to public inspection.

After the public opening, the Committee shall review the proposals, examining the cost and quality of the products, the reputation and capabilities of the insurance companies submitting the proposals, and other appropriate criteria. The Committee shall determine which proposal, if any, would meet the needs and desires of the employees of that Committee's payroll unit and shall award a payroll deduction slot to the company submitting the proposal that meets those needs and desires. The Committee may reject any or all proposals.

A company may seek to modify or withdraw a proposal only after the public opening and only on the basis that the proposal contains an unintentional clerical error as opposed to an error in judgment. A company seeking to modify or withdraw a proposal shall submit to the Committee a written request, with facts and evidence in support of its position, prior to the award of the payroll deduction slot, but not later than two days after the public opening of the proposals. The Committee shall promptly review the request, examine the nature of the error, and determine whether to permit or deny the request.

(d) Criminal Penalty. — It shall be a Class 3 misdemeanor for any State employee, who has supervisory authority over any member of the Employee Insurance Committee, to attempt to influence the autonomy of any Employee Insurance Committee either in the appointment of members to such Committee or in the operation of such Committee; or for anyone to open a sealed insurance product proposal or disclose or exhibit the contents of a sealed insurance product proposal, prior to the public opening of the proposal. The Commissioner of Insurance shall have the authority to investigate complaints alleging acts subject to the criminal penalty and shall report his findings to the Attorney General of North Carolina. (1985, c. 213, s. 1; 1985 (Reg. Sess., 1986), c. 1013, s. 15; 1987, c. 752, s. 12; c. 864, s. 92; 1989, c. 299; 1991, c. 644, s. 3.1; 1993, c. 539, s. 456; 1994, Ex. Sess., c. 24, s. 14(c); 1995, c. 193, s. 33.)

Editor's Note. —
Session Laws 1995, c. 193, s. 67, contains a severability clause.

ARTICLE 32.

Public Officers and Employees Liability Insurance Commission.

§ 58-32-1. Commission created; membership.

There is hereby created within the Department a Public Officers and Employees Liability Insurance Commission. The Commission shall consist of 11 members who shall be appointed as follows: the Commissioner shall appoint six members as follows: two members who are members of the insurance industry who may be chosen from a list of three nominees submitted to the Commissioner by the Independent Insurance Agents of North Carolina, Inc., and a list of three nominees submitted by the Carolinas Association of Professional Insurance Agents, North Carolina Division; one member who is employed by a police department who may be chosen from a list of three nominees submitted to the Commissioner jointly by the North Carolina Police Chiefs Association and North Carolina Police Executives Association, and one member who is employed by a sheriff's department who may be chosen from a list of three nominees submitted to the Commissioner by the North Carolina Sheriff's Association; one member representing city government who may be chosen from a list of three nominees submitted to the Commissioner by the North Carolina League of Municipalities; and one member representing county government who may be chosen from a list of three nominees submitted to the Commissioner by the North Carolina Association of County Commissioners; and the General Assembly shall appoint two persons, one upon the recommendation of the Speaker of the House of Representatives, and one upon the recommendation of the President Pro Tempore of the Senate. The Commissioner or his designate shall be an ex officio member. Appointments by the General Assembly shall be made in accordance with G.S. 120-121, and vacancies in those appointments shall be filled in accordance with G.S. 120-122. The terms of the initial appointees by the General Assembly shall expire on June 30, 1983. The Secretary of the Department of Crime Control and Public Safety or his designate shall be an ex officio member. The Attorney General or his designate shall be an ex officio member. One insurance industry member appointed by the Commissioner shall be appointed to a term of two years and one insurance industry member shall be appointed to a term of four years. The police department member shall be appointed to a term of two years and the sheriff's department member shall be appointed to a term of four years. The representative of county government shall be appointed to a term of two years and the representative of city government to a term of four years. Beginning July 1, 1983, the appointment made by the General Assembly upon the recommendation of the Speaker shall be for two years, and the appointment made by the General Assembly upon the recommendation of the President Pro Tempore of the Senate shall be for four years. Except as provided in this section, if any vacancy occurs in the membership of the Commission, the appointing authority shall appoint another person to fill the unexpired term of the vacating member. After the initial terms established herein have expired, all appointees to the Commission shall be appointed to terms of four years.

The Commission members shall elect the chairman and vice-chairman of the Commission. The Commission may, by majority vote, remove any member of the Commission for chronic absenteeism, misfeasance, malfeasance or other good cause. (1979, c. 325, s. 1; 1981 (Reg. Sess., 1982), c. 1191, ss. 24-26; 1983, c. 543, ss. 1, 2; 1985, c. 666, ss. 76, 77, 79; 1991, c. 720, s. 4; 1995, c. 490, s. 41.)

Editor's Note. — Session Laws 1995, c. 490, which amended this section by adding "Pro Tempore" in the second and eleventh sentences, in s. 65 provides: "This act applies with respect to terms beginning on or after January 1, 1997, and to vacancies occurring on or after that date regardless of the date the term began."

§ 58-32-15. Professional liability insurance for State officials.

Editor's Note. — Session Laws 1997-443, s. 32.20(m), provides: "Upon ownership of all voting stock in the North Carolina Railroad Company by the State of North Carolina, and upon the request of the Board of Directors of the North Carolina Railroad Company, the Public Officers and Employees Liability Insurance Commission shall effect and place coverage for the officers, directors, and employees of the North Carolina Railroad under G.S. 58-32-15. The North Carolina Railroad Company shall pay the premiums for this insurance at rates established by the Commission, and shall make any other payments required by G.S. 143-300.6. Coverage of the officers, directors, and employees of the North Carolina Railroad company under this subsection shall not be construed as defining the North Carolina Railroad Company as a public body or as defining its officers, directors, or employees as public officials or employees for any other purpose."

ARTICLE 33.

Licensing of Agents, Brokers, Limited Representatives, and Adjusters.

§ 58-33-20. Representation.

CASE NOTES

Cited in Webster Enters., Inc. v. Selective Ins. Co., 125 N.C. App. 36, 479 S.E.2d 243 (1996).

§ 58-33-25. General license requirements.

(a) No person shall act as or hold himself out to be an agent, broker, limited representative, adjuster, or motor vehicle damage appraiser unless duly licensed.

(b) No agent, broker, or limited representative shall make application for, procure, negotiate for or place for others, any policies for any kinds of insurance as to which he is not then qualified and duly licensed.

(c) An agent or broker may be licensed for the following kinds of insurance:

(1) Life and Health Insurance
(2) Repealed by Session Laws 1993, c. 409, s. 1.1, effective July 1, 1993.
(3) Property and Liability Insurance
(4) Repealed by Session Laws 1989, c. 485, s. 17, effective June 28, 1989.
(5) Title Insurance
(6) Repealed by Session Laws 1989, c. 485, s. 17, effective June 28, 1989.
(7) Automobile Physical Damage.
(8) Medicare Supplement Insurance and Long-Term Care Insurance, as a supplement to a license for the kinds of insurance listed in subdivision (1) of this subsection.

(d) A property and liability insurance license shall not authorize an agent to sell accident and health insurance. An agent must hold a life and health insurance license to sell accident and health insurance.

(d1) A life and health insurance license authorizes an agent to sell variable contracts, if the agent satisfies the Commissioner that he has met the NASD requirements of the Secretary of State of North Carolina.

(d2) A life and health license authorizes an agent to sell Medicare supplement and long-term care insurance policies as defined respectively in Articles 54 and 55 of this Chapter, provided that the licensee takes and passes a supplemental written examination for such insurance as provided in G.S. 58-33-30(e) and pays the supplemental registration fee provided in G.S. 58-33-125(c).

(e) A limited representative may receive qualification for one or more licenses without examination for the following kinds of insurance:

(1), (2) Repealed by Session Laws 1989, c. 485, s. 19.
(3) Credit Life, Accident and Health.
(4) Credit, as specified in G.S. 58-7-15(17).
(5) Travel Accident and Baggage.
(6) Motor Club.
(7) Dental Services.
(8) Credit Property Insurance and Single Interest Automobile Physical Damage Insurance when either is made in connection with a loan.
(9) Repealed by Session Laws 1995 (Regular Session, 1996), c. 726, s. 20, effective January 1, 1997.
(10) Credit unemployment.
(11) Vehicle service agreements and mechanical breakdown insurance.
(12) Prearrangement insurance, as defined in G.S. 58-60-35(a)(2), when offered or sold by a preneed sales licensee

licensed under Article 13D of Chapter 90 of the General Statutes.

(e1) Expired.

(f) No licensed agent, broker or limited representative shall solicit anywhere in the boundaries of this State, or receive or transmit an application or premium of insurance, for a company not authorized to do business in the State, except as provided in G.S. 58-28-5 and Article 21 of this Chapter.

(g) No agent shall place a policy of insurance with any insurer unless he has a current appointment as agent for the insurer in accordance with G.S. 58-33-40 or has a valid temporary license issued in accordance with G.S. 58-33-65.

(h) A partnership or corporation that negotiates or solicits insurance may be licensed as an agent, broker, or limited representative provided that it maintains a place of business in this State. Every member of the partnership and every officer, director, stockholder, and employee of the corporation personally engaged in this State in soliciting or negotiating policies of insurance shall be registered with the Commissioner and each such member, officer, director, stockholder or employee shall also qualify as an individual licensee. The partnership or corporate licensee shall within 30 days notify the Commissioner of any addition to or deletion from the list of registered individuals.

(i) The Commissioner shall not grant, renew, or continue any license if he finds that the license is being or will be used by the licensee or applicant for the purpose of writing controlled business. Controlled business means:

(1) Insurance written on the interests of the licensee or of his immediate family or of his employer; or

(2) Insurance covering himself; members of his immediate family; a corporation or partnership of which he or a member of his immediate family is an officer, director, substantial stockholder, partner, or employee; or the officers, directors, substantial stockholders, partners or employees of such a corporation or partnership; provided, however, that nothing in this subsection applies to insurance written in connection with credit transactions.

(3) Such a license shall be deemed to have been, or intended to be, used for the purpose of writing controlled business, if the Commissioner finds that during any 12-month period the aggregate commissions earned from such controlled business have exceeded fifty percent (50%) of the aggregate commissions earned on all business written by such applicant or licensee during the same period.

(j) No insurer, agent, broker, or limited representative shall pay, directly or indirectly, any commission, brokerage or other valuable consideration to any person for services as an agent, broker, or limited representative within this State, unless such person at the time such services were performed held a valid license for that kind of insurance and appropriate company appointments as required by this Article for such services.

(k) Only agents who are duly licensed with appropriate company appointments, licensed brokers, or licensed limited representatives may accept, directly or indirectly, any commission, brokerage, or other valuable consideration: Provided, however, any individual duly appointed and licensed under this Article may pay his commissions or assign his commissions, or direct that his commissions be paid, to a partnership of which he is a member, employee, or agent, or to a corporation of which he is an officer, employee, or agent; provided further that this section does not prevent payment or receipt of renewal or other deferred commissions to or by any person entitled thereto under this section.

(*l*) The license shall state the name and Social Security or other identifying number of the licensee, date of issue, kind or kinds of insurance covered by the license, and such other information as the Commissioner deems to be proper.

(m) A license issued to an agent authorizes him to act until his license is otherwise suspended or revoked. Upon the suspension or revocation of a license, the licensee or any person having possession of such license shall return it to the Commissioner.

(n) A license of a broker, limited representative, adjuster, or motor vehicle damage appraiser shall be renewed on April 1st of each year and renewal fees shall be paid. The Commissioner is not required to print licenses for the purpose of renewing licenses. The Commissioner is authorized to establish for such licenses "staggered" license renewal dates that will apportion renewals throughout each calendar year. If such a system of staggered licensing is adopted, the Commissioner is authorized to extend the licensure period for some licensees. License renewal fees prescribed by G.S. 58-33-125 shall be prorated to the extent they are commensurate with such extensions.

(o) No license as an agent, broker, or limited representative is required of the following:

(1) Any regular salaried officer or employee of an insurance company, of a licensed agent, of a broker, or of a limited representative, if such officer's or employee's duties and responsibilities do not include the negotiation or solicitation of insurance.

(2) Persons who secure and furnish information on behalf of an employer, where no commission is paid for such service, for the purpose of group or wholesale life insurance, annuities, or group, blanket or franchise health insurance; or for enrolling individuals under such plans or issuing certificates thereunder; or otherwise assisting in administering such plans.

(3) Employers or their officers or employees, or the trustees of any employee trust plan, to the extent that such employers, officers, employees, or trustees are engaged in the administration or operation of any program of employee benefits for their own employees or the employees of their subsidiaries or affiliates involving the use of insurance issued by a licensed insurance company; provided that such employers, officers, employees, or trustees are not in any manner compensated, directly or indirectly, by the insurance company issuing such insurance.

(4) Agency office employees acting within the confines of the agent's office, under the direction and personal supervision of the duly licensed agent and within the scope of the agent's license, in the acceptance of applications, personally underwritten by the agent, payment of premiums, and the performance of clerical, stenographic, and similar office duties; provided that the activity does not amount to the

interpretation of insurance policies, provisions or coverage, to sales or negotiation of insurance policies, to any underwriting function, or to the signing or verification of applications for insurance.

(5) Licensed insurers authorized to write the kinds of insurance described in G.S. 58-7-15(1) through G.S. 58-7-15(3) that do business without the involvement of a licensed agent. (1987, c. 629, s. 1; c. 864, ss. 78, 79, 87; 1987 (Reg. Sess., 1988), c. 975, s. 10; 1989, c. 485, ss. 17-20; 1989 (Reg. Sess., 1990), c. 941, ss. 1, 2; 1991, c. 398, s. 1; c. 562, s. 1; c. 644, s. 16; c. 720, s. 75; 1993, c. 226, s. 16; c. 409, ss. 1.1, 8; c. 504, ss. 22-25; 1995, c. 517, s. 16; 1995 (Reg. Sess., 1996), c. 726, ss. 14, 20.)

Editor's Note. —

Session Laws 1995, c. 517, s. 41, contains a severability clause.

Session Laws 1995 (Reg. Sess., 1996), c. 726, s. 14, effective June 21, 1996, and expiring January 1, 1997, added subsection (e1), which read: "If a license is issued to a bail bondsman or a runner under this Article and under Article 71 of this Chapter and the license issued under Article 71 of this Chapter is suspended or revoked for cause or is not renewed for failure to pay the renewal fee, the license issued under this Article is suspended, revoked, or not renewed as of the date the order under Article 71 of this Chapter is final."

Session Laws 1995 (Reg. Sess., 1996), c. 726, s. 21, provides: "All surety bondsmen holding licenses issued under G.S. 58-33-25(e)(9) shall be issued surety bondsmen licenses under Article 71 of Chapter 58 of the General Statutes."

Session Laws 1995 (Reg. Sess., 1996), c. 726, s. 22, is a severability clause.

Effect of Amendments. — Session Laws 1995 (Reg. Sess., 1996), c. 726, c. 20, effective January 1, 1997, repealed subdivision (e)(9).

CASE NOTES

Cited in Beneficial N.C., Inc. v. State ex rel. N.C. State Banking Comm'n, — N.C. App. —, 484 S.E.2d 808 (1997).

§ 58-33-100. Payment of premium to agent valid; obtaining by fraud a crime.

(a) Any agent, broker or limited representative who acts for a person other than himself negotiating a contract of insurance is, for the purpose of receiving the premium therefor, the company's agent, whatever conditions or stipulations may be contained in the policy or contract. This subsection does not apply to the Insurance Underwriting Association established under Article 45 of this Chapter or the Joint Underwriting Association established under Article 46 of this Chapter.

(b) Any agent, broker or limited representative knowingly procuring by fraudulent representations payment, or the obligation for the payment, of a premium of insurance, shall be guilty of a Class 1 misdemeanor. (1987, c. 629, s. 1; 1993, c. 539, s. 458; 1994, Ex. Sess., c. 24, s. 14(c); 1997-498, s. 4.)

Editor's Note. —

Session Laws 1997-498, s. 14, is a severability clause.

Effect of Amendments. — The 1997 amendment, effective October 1, 1997, added the subsection designations, added the last sentence of subsection (a), and substituted "Any" for "Such" at the beginning of subsection (b).

§ 58-33-120. Agent, adjuster, etc., acting without a license or violating insurance law.

CASE NOTES

Cited in Beneficial N.C., Inc. v. State ex rel. N.C. State Banking Comm'n, — N.C. App. —, 484 S.E.2d 808 (1997).

§ 58-33-125. Fees.

Editor's Note. —

Session Laws 1995, c. 507, s. 11A(c), amended Session Laws 1989 (Reg. Sess., 1990), c. 1069, s. 31, deleting the last sentence regarding the expiration of amendments to the General Statutes by Session Laws 1989 (Reg. Sess., 1990), c. 1069, if the legislature did not appropriate or transfer funds. Session Laws 1989 (Reg. Sess., 1990), s. 31, as amended by Session Laws 1995, c. 507, s. 11A(c), provides: "Section 23 [see § 58-36-70] of this act does not apply to the 1990 automobile rate filing made pursuant to Article 36 of Chapter 58 of the General Statutes. Section 27 [§ 143-3.6] of this act shall expire at the end of the 1993-1994 fiscal year and Section 28 [§ 143-3.7] shall become effective upon the expiration of Section 27."

Session Laws 1995, c. 507, s. 1.1, provides that that act shall be known and cited as the Expansion and Capital Improvements Appropriations Act of 1995.

Session Laws 1995, c. 507, s. 28.9, provides: "Except for statutory changes or other provisions that clearly indicate an intention to have effects beyond the 1995-97 fiscal biennium, the textual provisions of this act apply only to funds appropriated for, and activities occurring during, the 1995-97 biennium."

§ 58-33-132. Qualifications of instructors.

(a) The Commissioner may adopt rules to establish requisite qualifications for and issuance, renewal, summary suspension, and termination of provider, presenter, and instructor authority for prelicensing and continuing insurance education courses. During any suspension, the instructor shall not engage in any instruction of prelicensing or continuing insurance education courses prior to an administrative review. No person shall provide, present, or instruct any course unless that person has been qualified and possesses a certificate of authority from the Commissioner.

(b) The Commissioner may summarily suspend or terminate the authority of an instructor, course provider, or presenter if the course presentation:

(1) Is determined to be inaccurate; or

(2) Receives an evaluation of poor from any Department monitor and a majority of attendees responding to Department questionnaires about the presentation. (1995, c. 517, s. 17.)

Editor's Note. — Session Laws 1995, c. 517, s. 42, made this section effective upon ratification. The act was ratified July 29, 1995.

Session Laws 1995, c. 517, s. 41, contains a severability clause.

ARTICLE 34.

Agency and Management Contracts.

§ 58-34-2. Managing general agents.

(a) As used in this Article:

(1) "Control", including the terms "controlling", "controlled by", and "under common control", means the direct or indirect possession of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person.

(2) "Insurer" means a domestic insurer but does not mean a reciprocal regulated under Article 15 of this Chapter.

(3) "Managing general agent" or "MGA" means any person who manages all or part of the insurance business of an insurer (including the management of a separate division, department, or underwriting office) and acts as an agent for the insurer, whether known as a managing general agent, manager, or other similar term, who, with or without the authority, either separately or together with persons under common control, produces, directly or indirectly, and underwrites an amount of gross direct written premium equal to or more than five percent (5%) of the policyholder surplus as reported in the last annual statement of the insurer in any one quarter or year together with one or more of the following activities related to the business produced: (i) adjusts or pays any claims, or (ii) negotiates reinsurance on behalf of the insurer. "MGA" does not mean an employee of the insurer; an underwriting manager who, pursuant to contract, manages all or part of the insurance operations of the insurer, is under common control with the insurer, is subject to Article 19 of this Chapter, and whose compensation is not based on the volume of premiums written; a person who, under Article 15 of this Chapter, is designated and authorized by subscribers as the attorney-in-fact for a reciprocal having authority to obligate them on reciprocal and other insurance contracts; or a U.S. Manager of the United States branch of an alien insurer.

(4) "Qualified actuary" means a person who meets the standards of a qualified actuary as specified in the NAIC Annual Statement Instructions, as amended or clarified by rule, order, directive, or bulletin of the Department, for the type of insurer for which the MGA is establishing loss reserves.

(5) "Underwrite" means the authority to accept or reject risk on behalf of the insurer.

(b) Control is presumed to exist if any person directly or indirectly owns, controls, holds with the power to vote, or holds proxies representing ten percent (10%) or more of the voting securities of any other person. The Commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect. The Commissioner may determine upon application that any person does not or will not upon the taking of some proposed action control another person. The Commissioner may prospectively revoke or modify that determination, after the notice and opportunity to be heard, whenever, in the Commissioner's judgment, revocation, or modification is consistent with this Article.

(c) No person shall act as an MGA with respect to risks located in this State for an insurer unless that person is a licensed agent in this State. No person shall act as an MGA representing an insurer with respect to risks located outside of this State unless that person is licensed as an agent in this State; and the license may be a nonresident license. The Commissioner may require a bond in an amount acceptable to the Commissioner for the protection of the insurer. The Commissioner may require the MGA to maintain an errors and omissions policy.

(d) No person acting as an MGA shall place business with an insurer unless there is in force a written contract between the MGA and the insurer that sets forth the responsibilities of each party and, where both parties share responsibility for a particular function, specifies the division of such responsibilities, and that contains the following minimum provisions:

(1) The insurer may terminate the contract for cause upon written notice to the MGA. The insurer may suspend the underwriting authority of the MGA during the pendency of any dispute regarding the cause for termination.

(2) The MGA will render accounts to the insurer detailing all transactions and remit all funds due under the contract to the insurer on not less than a monthly basis.

(3) All funds collected for the account of an insurer will be held by the MGA in a fiduciary capacity in a bank that is a member of the Federal Reserve System. This account shall be used for all payments on behalf of the insurer. The MGA may retain no more than three months estimated claims payments and allocated loss adjustment expenses.

(4) Separate records of business written by the MGA will be maintained. The insurer shall have access to and right to copy all accounts related to its business in a form usable by the insurer, and the Commissioner shall have access to all books, bank accounts, and records of the MGA in a form usable to the Commissioner. The records shall be retained according to the provisions of 11 NCAC 11C.0105.

(5) The contract may not be assigned in whole or part by the MGA.

(6) Appropriate underwriting guidelines, including: the maximum annual premium volume; the basis of the rates to be charged; the types of risks that may be written; maximum limits of liability; applicable exclusions; territorial limitations; policy cancellation provisions; and the maximum policy period. The insurer shall have the right to cancel or nonrenew any policy of insurance subject to applicable laws and rules.

(7) If the contract permits the MGA to settle claims on behalf of the insurer:

a. All claims must be reported to the insurer in a timely manner.

b. A copy of the claim file will be sent to the insurer at its request or as soon as it becomes known that the claim: has the potential to exceed an amount determined by the insurer and approved by the Commissioner; involves a coverage dispute; may exceed the MGA's claims settlement authority; is open for more than six months; or is closed by payment of an amount set by the insurer and approved by the Commissioner.

c. All claim files will be the joint property of the insurer and MGA. However, upon an order of liquidation of the insurer the files shall become the sole property of the insurer or its estate; the MGA shall have reasonable access to and the right to copy the files on a timely basis.

d. Any settlement authority granted to the MGA may be terminated for cause upon the insurer's written notice to the MGA or upon the termination of the contract. The insurer may suspend the settlement authority during the pendency of any dispute regarding the cause for termination.

(8) Where electronic claims files are in existence, the contract must address the timely transmission of the data.

(9) If the contract provides for a sharing of interim profits by the MGA, and the MGA has the authority to determine the amount of the interim profits by establishing loss reserves, controlling claim payments, or by any other manner, interim profits will not be paid to the MGA until one year after they are earned for property insurance business and five years after they are earned on casualty business and not until the profits have been verified under subsection (f) of this section.

(10) The MGA shall not:

a. Bind reinsurance or retrocessions on behalf of the insurer, except that the MGA may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the insurer contains reinsurance underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which such automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured, and commission schedules;

b. Commit the insurer to participate in insurance or reinsurance syndicates;

c. Appoint any producer without assuring that the producer is lawfully licensed to transact the type of insurance for which the producer is appointed;

d. Without prior approval of the insurer, pay or commit the insurer to pay a claim over a specified amount, net of reinsurance, which shall not exceed one percent (1%) of the insurer's policyholder's surplus as of the preceding December 31;

e. Collect any payment from a reinsurer or commit the insurer to any claim settlement with a reinsurer, without the insurer's prior approval. If prior approval is given, a report must be promptly forwarded to the insurer;

f. Permit its subproducer to serve on the insurer's board of directors;
g. Jointly employ an individual who is employed with the insurer; or
h. Appoint a sub-MGA.

(e) An insurer shall have on file by June 1 of each year an audited financial report of each MGA with which it is doing business. The report shall include the opinion of an independent certified public accountant, report the financial position of the MGA as of the most recent year-end and the results of its operations and cash flows, and include appropriate notes to financial statements. The insurer shall provide a copy of the report to the Commissioner within 15 days of receipt by the insurer.

(f) If an MGA establishes loss reserves, the insurer shall provide with its annual statement, in addition to any other required statement of actuarial opinion, the statement of a qualified actuary attesting to the adequacy of loss reserves established on business produced by the MGA. The statement shall comply in all respects with the NAIC Annual Statement Instructions regarding the Statement of Actuarial Opinion.

(g) The insurer shall periodically, at least semiannually, conduct an on-site review of the underwriting and claims processing operations of the MGA. The insurer shall prepare and maintain a written report on the review and make it available to the Commissioner upon the Commissioner's request.

(h) Binding authority for all reinsurance contracts, except those contracts expressly permitted under sub-subdivision (d)(10)a. of this section, or participation in insurance or reinsurance syndicates, shall rest with an officer of the insurer, who shall not be affiliated with the MGA.

(i) Within 15 days after entering into or termination of a contract with an MGA, the insurer shall provide written notification of the appointment or termination to the Commissioner. Notices of appointment of an MGA shall include a copy of the contract, a statement of duties that the MGA is expected to perform on behalf of the insurer, the lines of insurance for which the MGA is to be authorized to act, whether any affiliation exists between the insurer and the MGA and the basis for the affiliation, NAIC biographical affidavit for each officer, director, and each person who owns ten percent (10%) or more of the outstanding voting stock of the MGA, and any other information the Commissioner may request. The Commissioner may prescribe the form to be used for notification of the information required by this item.

(j) The Commissioner shall disapprove any such contract that:
(1) Does not contain the required contract provisions specified in subsection (d) of this section;
(2) Subjects the insurer to excessive charges for expenses or commission;
(3) Vests in the MGA any control over the management of the affairs of the insurer to the exclusion of the board of directors of the insurer;
(4) Is entered into with any person if the person or its officers and directors are of known bad character or have been affiliated directly or indirectly through ownership, control, management, reinsurance transactions, or other insurance or business relationships with any person known to have

been involved in the improper manipulation of assets, accounts, or reinsurance; or

(5) Is determined by the Commissioner to contain provisions that are not fair and reasonable to the insurer.

Failure of the Commissioner to disapprove any such contract within 30 days after the contract has been filed with the Commissioner constitutes the Commissioner's approval of the contract. An insurer may continue to accept business from such person until the Commissioner disapproves the contract. Any disapproval shall be in writing. The Commissioner may, after a hearing held under G.S. 58-2-50, withdraw approval of any contract the Commissioner has previously approved upon finding that the basis of the original approval no longer exists or that the contract has, in actual operation, shown itself to be subject to disapproval on any of the grounds in this subsection.

(k) An insurer shall review its books and records each quarter to determine if any agent has become an MGA. If the insurer determines that an agent has become an MGA, the insurer shall promptly notify the agent of that determination and the insurer and agent must fully comply with the provisions of this Article within 15 days.

(*l*) An insurer shall not appoint to its board of directors an officer, director, employee, subagent, or controlling shareholder of its MGAs. This subsection does not apply to relationships governed by Article 19 of this Chapter or, if applicable, G.S. 58-3-165.

(m) The acts of an MGA are considered to be the acts of the insurer on whose behalf it is acting. An MGA may be examined by the Commissioner under G.S. 58-2-131, 58-2-132, or 58-2-133 as if it were an insurer.

(n) If the Commissioner determines that an MGA or any other person has not materially complied with this section or with any rule adopted or order issued under this section, after notice and opportunity to be heard, the Commissioner may order:

(1) For each separate violation, a civil penalty under the procedures in G.S. 58-2-70(d); or

(2) Revocation or suspension of the person's license.

(3) Repealed by Session Laws 1993, c. 452, s. 47, effective October 1, 1993.

If the Commissioner finds that because of a material noncompliance that an insurer has suffered any loss or damage, the Commissioner may maintain a civil action brought by or on behalf of the insurer and its policyholders and creditors for recovery of compensatory damages for the benefit of the insurer and its policyholders and creditors or for other appropriate relief.

(o) Nothing in this section affects the Commissioner's right to impose any other penalties provided for in this Chapter. Nothing in this Article limits or restricts the rights of policyholders, claimants, and creditors.

(p) If an order of rehabilitation or liquidation of the insurer has been entered under Article 30 of this Chapter, and the receiver appointed under that order determines that the MGA or any other person has not materially complied with this section, or any regulation or order promulgated thereunder, and the insurer suffered any loss or damage therefrom, the receiver may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the insurer. (1991, c. 681, s. 51; 1993, c. 452, ss. 43-48; 1993 (Reg. Sess., 1994), c. 678, s. 19; 1995, c. 193, s. 34.)

Editor's Note. — Session Laws 1995, c. 193, s. 67 contains a severability clause.

ARTICLE 35.

Insurance Premium Financing.

§ 58-35-5. License required; fees.

Editor's Note. — Session Laws 1995, c. 507, s. 11A(c), amended Session Laws 1989 (Reg. Sess., 1990), c. 1069, s. 31, deleting the last sentence regarding the expiration of amendments to the General Statutes by Session Laws 1989 (Reg. Sess., 1990), c. 1069, if the legislature did not appropriate or transfer funds. Session Laws 1989 (Reg. Sess., 1990), s. 31, as amended by Session Laws 1995, c. 507, s. 11A(c), provides: "Section 23 [see § 58-36-70] of this act does not apply to the 1990 automobile rate filing made pursuant to Article 36 of Chapter 58 of the General Statutes. Section 27 [§ 143-3.6] of this act shall expire at the end of the 1993-1994 fiscal year and Section 28 [§ 143-3.7] shall become effective upon the expiration of Section 27."

Session Laws 1995, c. 507, s. 1.1, provides that that act shall be known and cited as the Expansion and Capital Improvements Appropriations Act of 1995.

Session Laws 1995, c. 507, s. 28.9, provides: "Except for statutory changes or other provisions that clearly indicate an intention to have effects beyond the 1995-97 fiscal biennium, the textual provisions of this act apply only to funds appropriated for, and activities occurring during, the 1995-97 biennium."

§ 58-35-10. Exceptions to license requirements.

(a) Any person, firm or corporation doing business under the authority of any law of this State or of the United States relating to banks, trust companies, installment paper dealers, auto finance companies, savings and loan associations, cooperative credit unions, agricultural credit corporations or associations, organized under the laws of North Carolina or any person, firm or corporation subject to the provisions of the North Carolina Consumer Finance Act and the North Carolina Motor Vehicle Dealers and Manufacturers Licensing Law, Article 12, Chapter 20, of the General Statutes of North Carolina are exempt from the provisions of this Article.

(b) An insurance company duly licensed in this State may make an installment payment charge as set forth in the rate filings and approved by the Commissioner and is thereby exempt from the provisions of this Article.

(c) A fire and casualty insurance agent or an insurance broker duly licensed in this State who extends credit to and only to his own policyholders may charge and collect finance charges or other fees at a periodic (monthly) rate as provided in G.S. 24-11(a), after said amount has been outstanding for 30 days, and is hereby exempt from the provisions of this Article. Notwithstanding the exceptions set forth in subsections (a), (b) and (c) of this section, when any person, firm, or corporation shall exercise a power of attorney taken in connection with the financing of an insurance premium, such person, firm or corporation shall comply with the requirements of G.S. 58-35-85, as if it were an insurance premium financing company. (1963, c. 1118; 1967, c. 942, s. 1; 1971, c. 1186, ss. 1, 2; 1995 (Reg. Sess., 1996), c. 742, s. 25.)

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective June 21, 1996, substituted "is" for "are" preceding "thereby exempt" in subsection (b).

§ 58-35-85. Procedure for cancellation of insurance contract upon default; return of unearned premiums; collection of cash surrender value.

When an insurance premium finance agreement contains a power of attorney or other authority enabling the insurance premium finance company to cancel any insurance contract or contracts listed in the agreement, the insurance contract or contracts shall not be cancelled unless the cancellation is effectuated in accordance with the following provisions:

(1) Not less than 10 days' written notice be mailed to the last known address of the insured or insureds shown on the insurance premium finance agreement of the intent of the insurance premium finance company to cancel his or their insurance contract or contracts unless the defaulted installment payment is received. A notice thereof shall also be sent to the insurance agent.

(2) After expiration of the period, the insurance premium finance company shall send the insurer a request for cancellation and shall mail a copy of the request for cancellation to the insured at his last known address as shown on the insurance premium finance agreement. The premium finance company shall include a copy of the power of attorney with the request for cancellation if the insurer has not already received a copy of the power of attorney with the application.

(3) Upon receipt of a copy of the request for cancellation notice by the insurer, the insurance contract shall be cancelled with the same force and effect as if the aforesaid request for cancellation had been submitted by the insured himself, without requiring the return of the insurance contract or contracts.

(4) All statutory, regulatory, and contractual restrictions providing that the insured may not cancel his insurance contract unless he first satisfies the restrictions by giving a prescribed notice to a governmental agency, the insurance carrier, an individual, or a person designated to receive the notice for said governmental agency, insurance carrier, or individual shall apply where cancellation is effected under the provisions of this section.

(5) Whenever an insurance contract is cancelled in accordance with this section, the insurer shall promptly return whatever gross unearned premiums are due under the contract to the insurance premium finance company effecting the cancellation for the benefit of the insured or insureds. Whenever the return premium is in excess of the amount due the insurance premium finance company by the insured under the agreement, the excess shall be remitted promptly to the order of the insured, subject to the minimum service charge provided for in this Article.

(6) The provisions of this section relating to request for cancellation by the insurance premium finance company of an

insurance contract and the return by an insurer of unearned premiums to the insurance premium finance company, also apply to the surrender by the insurance premium finance company of an insurance contract providing life insurance and the payment by the insurer of the cash value of the contract to the insurance premium finance company, except that the insurer may require the surrender of the insurance contract. (1963, c. 1118; 1967, c. 825; 1969, c. 941; 1987, c. 864, s. 22; 1995, c. 121, s. 1.)

CASE NOTES

Insurance policy was cancelled the day insurance company received the cancellation request from a premium financing company requesting cancellation because the insured defaulted on his payments. Unisun Ins. Co. v. Goodman, 117 N.C. App. 454, 451 S.E.2d 4 (1994).

Compliance Not Shown. — While insurance premium finance company did comply with the requirement that cancellation notice have the wording "Notice of Cancellation" in bold print at the top, company did not comply with this section's requirements since it failed to mail the insurer a request for cancellation, including a copy of the power of attorney, and to mail a copy of the request for cancellation to the insured. GEICO v. New South Ins. Co., 119 N.C. App. 700, 459 S.E.2d 817 (1995).

ARTICLE 36.

North Carolina Rate Bureau.

§ 58-36-1. North Carolina Rate Bureau created.

There is hereby created a Bureau to be known as the "North Carolina Rate Bureau," with the following objects and functions:

(1) To assume the functions formerly performed by the North Carolina Fire Insurance Rating Bureau, the North Carolina Automobile Rate Administrative Office, and the Compensation Rating and Inspection Bureau of North Carolina, with regard to the promulgation of rates, for insurance against loss to residential real property with not more than four housing units located in this State and any contents thereof and valuable interest therein and other insurance coverages written in connection with the sale of such property insurance; for theft of and physical damage to private passenger (nonfleet) motor vehicles as the same are defined under Article 40 of this Chapter; for liability insurance for such motor vehicles, automobile medical payments insurance, uninsured motorists coverage and other insurance coverages written in connection with the sale of such liability insurance; and for workers' compensation and employers' liability insurance written in connection therewith except for insurance excluded from the Bureau's jurisdiction in G.S. 58-36-1(3).

(2) The Bureau shall provide reasonable means to be approved by the Commissioner whereby any person affected by a rate made by it may be heard in person or by his authorized representative before the governing committee or other proper executive of the Bureau.

(3) The Bureau shall have the duty and responsibility of promulgating and proposing rates for insurance against loss to residential real property with not more than four housing units located in this State and any contents thereof or valuable interest therein and other insurance coverages written in connection with the sale of such property insurance; for insurance against theft of or physical damage to private passenger (nonfleet) motor vehicles; for liability insurance for such motor vehicles, automobile medical payments insurance, uninsured motorists coverage and other insurance coverages written in connection with the sale of such liability insurance; and, as provided in G.S. 58-36-100, for loss costs and residual market rate filings for workers' compensation and employers' liability insurance written in connection therewith. The provisions of this subdivision shall not apply to motor vehicles operated under certificates of authority from the Utilities Commission, the Interstate Commerce Commission, or their successor agencies, where insurance or other proof of financial responsibility is required by law or by regulations specifically applicable to such certificated vehicles. The Bureau shall have no jurisdiction over excess workers' compensation insurance for employers qualifying as self-insurers as provided in G.S. 97-93; nor shall the Bureau's jurisdiction include farm buildings, farm dwellings and their appurtenant structures, farm personal property or other coverages written in connection with farm real or personal property; travel or camper trailers designed to be pulled by private passenger motor vehicles, unless insured under policies covering nonfleet private passenger motor vehicles; residential real and personal property insured in multiple line insurance policies covering business activities as the primary insurable interest; and marine, general liability, burglary and theft, glass, and animal collision insurance, except when such coverages are written as an integral part of a multiple line insurance policy for which there is an indivisible premium.

(4) Agreements may be made between or among members with respect to equitable apportionment among them of insurance which may be afforded applicants who are in good faith entitled to but who are unable to procure such insurance through ordinary methods. The members may agree between or among themselves on the use of reasonable rate modifications for such insurance, agreements, and rate modifications to be subject to the approval of the Commissioner.

(5)a. It is the duty of every insurer that writes workers' compensation insurance in this State and is a member of the Bureau, as defined in this section and G.S. 58-36-5 to insure and accept any workers' compensation insurance risk that has been certified to be "difficult to place" by any fire and casualty insurance agent who is licensed in this State. When any such risk is called to the attention of the Bureau by receipt of an application with an estimated or deposit premium payment and it appears that the risk is in good faith entitled to such coverage, the Bureau will bind coverage for 30 days and will designate a member who must issue a standard workers' compensation policy of insurance that contains the usual and customary provisions found in those policies. Multiple coordinated policies, as defined by the Bureau and approved by the Commissioner, may be used for the issuance of coverage under this subdivision for risks involved in employee leasing arrangements. Coverage will be bound at 12:01 A.M. on the first day following the postmark time and date on the envelope in which the application is mailed including the estimated annual or deposit premium, or the expiration of existing coverage, whichever is later. If there should be no postmark, coverage will be effective 12:01 A.M. on the date of receipt by the Bureau unless a later date is requested. Those applications hand delivered to the Bureau will be effective as of 12:01 A.M. of the date following receipt by the Bureau unless a later date is requested. The Bureau will make and adopt such rules as are necessary to carry this section into effect, subject to final approval of the Commissioner. As a prerequisite to the transaction of workers' compensation insurance in this State, every member of the Bureau that writes such insurance must file with the Bureau written authority permitting the Bureau to act in its behalf, as provided in this section, and an agreement to accept risks that are assigned to the member by the Bureau, as provided in this section.

b. The Bureau shall maintain a compendium of employers refused voluntary coverage, which shall be made available by the Bureau to all insurers, licensed agents, and self-insureds' administrators doing business in this State. It shall be stored and indexed to allow access to information by industry, primary classifications of employees, geography, experience modification, and in any other manner the Bureau determines is commercially useful to facilitate voluntary coverage of listed employers. The Bureau shall be immune from civil liability for erroneous information released by the Bureau pursuant to this section, provided that the Bureau acted in good faith and without malicious or willful intent to harm in releasing the erroneous information.

c. Failure or refusal by any assigned employer risk to make full disclosure to the Bureau, servicing carrier, or insurer writing a policy of information regarding the employer's true ownership, change of ownership, operations, or payroll, or any other failure to disclose fully any records pertaining to workers' compensation insurance shall be sufficient grounds for the Bureau to authorize the termination of the policy of that employer.

(6) The Bureau shall maintain and furnish to the Commissioner on an annual basis the statistics on earnings derived by member companies from the investment of unearned premium, loss, and loss expense reserves on nonfleet pri-

vate passenger motor vehicle insurance policies written in this State. Whenever the Bureau proposes rates under this Article, it shall prepare a separate exhibit for the experience years in question showing the combined earnings realized from the investment of such reserves on policies written in this State. The amount of earnings may in an equitable manner be included in the ratemaking formula to arrive at a fair and equitable rate. The Commissioner may require further information as to such earnings and may require calculations of the Bureau bearing on such earnings.

(7) Member companies shall furnish, upon request of any person carrying nonfleet private passenger motor vehicle insurance in the State upon whose risk a rate has been promulgated, information as to rating, including the method of calculation. (1977, c. 828, s. 6; 1981, c. 888, ss. 1-3; 1983, c. 416, s. 5; 1985 (Reg. Sess., 1986), c. 1027, s. 5.1; 1991, c. 339, s. 1; 1993, c. 409, s. 27; 1993 (Reg. Sess., 1994), c. 679, s. 8.5; 1995, c. 505, s. 1; c. 517, s. 18.)

Editor's Note. —

Subdivision (5) was amended by Session Laws 1993, c. 517, s. 18 in the coded bill drafting format prescribed by § 120-20.1. It is set out in the form above at the direction of the Revisor of Statutes.

Session Laws 1995, c. 517, s. 41, contains a severability clause.

CASE NOTES

Use of Rate Bureau Form Does Not Confer Jurisdiction over Fleet Policy. — By requiring rejection of underinsured motorist (UIM) coverage to be accomplished by use of a specific Rate Bureau form, § 20-279.21(b)(4) does not effectively confer additional jurisdictional authority to the Rate Bureau, but is merely concerned with avoiding confusion and ambiguity through the use of a single standard and approved form, and mandating use of a Rate Bureau form for rejection of UIM coverage within a fleet policy does not necessarily conflict with this section. Hendrickson v. Lee, 119 N.C. App. 444, 459 S.E.2d 275 (1995).

§ 58-36-2. Private passenger motor vehicles; number of nonfleet policies.

Notwithstanding the definition of "nonfleet" in G.S. 58-40-10(2), the Bureau shall adopt rules, subject to the Commissioner's approval, that specify the circumstances under which more than four private passenger motor vehicles may be covered under a nonfleet private passenger motor vehicle policy that is subject to this Article. (1995 (Reg. Sess., 1996), c. 730, s. 2.)

Editor's Note. — Session Laws 1995 (Reg. Sess., 1996), c. 730, s. 4, made this section effective January 1, 1997, and applicable to policies written on or after that date.

§ 58-36-10. Method of rate making; factors considered.

CASE NOTES

Filed rate doctrine, as adopted in North Carolina, precludes a claim for damages measured by the difference between the rates as approved by the commissioner and the rates which would have been approved but for the illegal conduct of the defendants; thus, the doctrine forbids the recalculation of commissioner-approved rates by a jury. N.C. Steel, Inc. v. National Council on Comp. Ins., 123 N.C. App. 163, 472 S.E.2d 578 (1996).

Filed rate doctrine does not act to bar any claims which involve damages other than inflated rates. N.C. Steel, Inc. v. National Council on Comp. Ins., 123 N.C. App. 163, 472 S.E.2d 578 (1996).

Plaintiff may not claim damages on the grounds that a rate filed with and approved by a regulator as reasonable was nonetheless excessive or inadequate because it was the product of an anticompetitive conspiracy or other unlawful conduct by the defendants. N.C. Steel, Inc. v. National Council on Comp. Ins., 123 N.C. App. 163, 472 S.E.2d 578 (1996).

Calculation of Rate Level. — The Commissioner provided for the appropriate amount for dividends and deviations in the profit provision by calculating the amount that was provided in his prospective rate level based on evidence in the record on existing levels. State ex rel. Comm'r of Ins. v. North Carolina Rate Bureau, 124 N.C. App. 674, 478 S.E.2d 794 (1996).

Investment Income Improperly Considered. — The Commissioner erred as a matter of law in considering investment income from capital and surplus in his ratemaking calculations. State ex rel. Comm'r of Ins. v. North Carolina Rate Bureau, 124 N.C. App. 674, 478 S.E.2d 794 (1996).

Premium-to-Surplus Ratio. — There was substantial evidence to support the Commissioner's selection of the traditional standard 2 to 1 for the premium-to-surplus ratio. State ex rel. Comm'r of Ins. v. North Carolina Rate Bureau, 124 N.C. App. 674, 478 S.E.2d 794 (1996).

Hypothetical Ratio. — There was nothing to preclude the Commissioner's use of a hypothetical normative premium-to-surplus ratio as opposed to the actual ratio where there was substantial evidence to support the Commissioner's selection. State ex rel. Comm'r of Ins. v. North Carolina Rate Bureau, 124 N.C. App. 674, 478 S.E.2d 794 (1996).

§ 58-36-15. Filing loss costs, rates, plans with Commissioner; public inspection of filings.

(a) The Bureau shall file with the Commissioner copies of the rates, loss costs, classification plans, rating plans and rating systems used by its members. Each rate filing shall become effective on the date specified in the filing, but not earlier than 105 days from the date the filing is received by the Commissioner: Provided that (1) rate filings for workers' compensation insurance and employers' liability insurance written in connection therewith shall not become effective earlier than 120 days from the date the filing is received by the Commissioner or on the date as provided under G.S. 58-36-100, whichever is earlier; and (2) any filing may become effective on a date earlier than that specified in this subsection upon agreement between the Commissioner and the Bureau.

(b) A filing shall be open to public inspection immediately upon submission to the Commissioner.

(c) The Bureau shall maintain reasonable records, of the type and kind reasonably adapted to its method of operation, of the experience of its members and of the data, statistics or information collected or used by it in connection with the rates, rating plans, rating systems, loss costs and other data as specified in G.S.

58-36-100, underwriting rules, policy or bond forms, surveys or inspections made or used by it.

(d) With respect to the filing of rates for nonfleet private passenger motor vehicle insurance, the Bureau shall, on or before February 1 of each year, or later with the approval of the Commissioner, file with the Commissioner the experience, data, statistics, and information referred to in subsection (c) of this section and any proposed adjustments in the rates for all member companies of the Bureau. The filing shall include, where deemed by the Commissioner to be necessary for proper review, the data specified in subsections (c), (e), (g) and (h) of this section. Any filing that does not contain the data required by this subsection may be returned to the Bureau and not be deemed a proper filing. Provided, however, that if the Commissioner concludes that a filing does not constitute a proper filing he shall promptly notify the Bureau in writing to that effect, which notification shall state in reasonable detail the basis of the Commissioner's conclusion. The Bureau shall then have a reasonable time to remedy the defects so specified. An otherwise defective filing thus remedied shall be deemed to be a proper and timely filing, except that all periods of time specified in this Article will run from the date the Commissioner receives additional or amended documents necessary to remedy all material defects in the original filing.

(e) The Commissioner may require the filing of supporting data including:

(1) The Bureau's interpretation of any statistical data relied upon;
(2) Descriptions of the methods employed in setting the rates;
(3) Analysis of the incurred losses submitted on an accident year or policy year basis into their component parts; to wit, paid losses, reserves for losses and loss expenses, and reserves for losses incurred but not reported;
(4) The total number and dollar amount of paid claims;
(5) The total number and dollar amount of case basis reserve claims;
(6) Earned and written premiums at current rates by rating territory;
(7) Earned premiums and incurred losses according to classification plan categories; and
(8) Income from investment of unearned premiums and loss and loss expense reserves generated by business within this State.

Provided, however, that with respect to business written prior to January 1, 1980, the Commissioner shall not require the filing of such supporting data which has not been required to be recorded under statistical plans approved by the Commissioner.

(f) On or before September 1 of each calendar year the Bureau shall submit to the Commissioner the experience, data, statistics, and information referred to in subsection (c) of this section and required under G.S. 58-36-100 and a residual market rate or prospective loss costs review based on such data for workers' compensation insurance and employers' liability insurance written in connection therewith. Any rate increase for such insurance that is implemented pursuant to this Article shall become effective solely to such insurance as is written having an inception date on or after the effective date of the rate increase.

(g) The following information must be included in policy form, rule, and rate filings under this Article and under Article 37 of this Chapter:

(1) A detailed list of the rates, rules, and policy forms filed, accompanied by a list of those superseded; and
(2) A detailed description, properly referenced, of all changes in policy forms, rules, prospective loss costs, and rates, including the effect of each change.

(h) Except to the extent the Commissioner determines that this subsection is inapplicable to filings made under G.S. 58-36-100 and except for filings made under G.S. 58-36-30, all policy form, rule, prospective loss costs, and rate filings under this Article and Article 37 of this Chapter that are based on statistical data must be accompanied by the following properly identified information:
(1) North Carolina earned premiums at the actual and current rate level; losses and loss adjustment expenses, each on paid and incurred bases without trending or other modification for the experience period, including the loss ratio anticipated at the time the rates were promulgated for the experience period;
(2) Credibility factor development and application;
(3) Loss development factor derivation and application on both paid and incurred bases and in both numbers and dollars of claims;
(4) Trending factor development and application;
(5) Changes in premium base resulting from rating exposure trends;
(6) Limiting factor development and application;
(7) Overhead expense development and application of commission and brokerage, other acquisition expenses, general expenses, taxes, licenses, and fees;
(8) Percent rate or prospective loss costs change;
(9) Final proposed rates;
(10) Investment earnings, consisting of investment income and realized plus unrealized capital gains, from loss, loss expense, and unearned premium reserves;
(11) Identification of applicable statistical plans and programs and a certification of compliance with them;
(12) Investment earnings on capital and surplus;
(13) Level of capital and surplus needed to support premium writings without endangering the solvency of member companies; and
(14) Such other information that may be required by any rule adopted by the Commissioner.

Provided, however, that no filing may be returned or disapproved on the grounds that such information has not been furnished if insurers have not been required to collect such information pursuant to statistical plans or programs or to report such information to the Bureau or to statistical agents, except where the Commissioner has given reasonable prior notice to the insurers to begin collecting and reporting such information, or except when the information is readily available to the insurers.

(i) The Bureau shall file with and at the time of any rate or prospective loss costs filing all testimony, exhibits, and other information on which the Bureau will rely at the hearing on the rate filing. The Department shall file all testimony, exhibits, and other information on which the Department will rely at the hearing on the rate filing 20 days in advance of the convening date of the hearing. Upon the issuance of a notice of hearing the Commissioner shall hold a meeting of the parties to provide for the scheduling of any additional testimony, including written testimony, exhibits or other information, in response to the notice of hearing and any potential rebuttal testimony, exhibits, or other information. This subsection also applies to rate filings made by the North Carolina Motor Vehicle Reinsurance Facility under Article 37 of this Chapter. (1977, c. 828, s. 6; 1979, c. 824, s. 2; 1981, c. 521, s. 1; 1985, c. 666, s. 3; 1985 (Reg. Sess., 1986), c. 1027, ss. 2, 3; 1993, c. 409, s. 10; 1995, c. 505, s. 2.)

Editor's Note. — Session Laws 1995, c. 505, s. 9, provides: "Notwithstanding G.S. 58-36-15(f), the Bureau may make its 1995 filing after September 1, 1995."

§ 58-36-25. Appeal of Commissioner's order.

(a) Any order or decision of the Commissioner shall be subject to judicial review as provided in Article 2 of this Chapter.

(b) Whenever a Bureau rate is held to be unfairly discriminatory or excessive and no longer effective by order of the Commissioner issued under G.S. 58-36-20, the members of the Bureau, in accordance with rules and regulations established and adopted by the governing committee, shall have the option to continue to use such rate for the interim period pending judicial review of such order, provided each such member shall place in escrow account the purportedly unfairly discriminatory or excessive portion of the premium collected during such interim period. Upon a final determination by the Court, or upon a consent agreement or consent order between the Bureau and the Commissioner, the Commissioner shall order the escrowed funds to be distributed appropriately. If refunds are to be made to policyholders, the Commissioner shall order that the members of the Bureau refund the difference between the total premium per policy using the rate levels finally determined and the total premium per policy collected during the interim period pending judicial review, except that refund amounts that are five dollars ($5.00) or less per policy shall not be required. The court may also require that purportedly excess premiums resulting from an adjustment of premiums ordered pursuant to G.S. 58-36-20(b) be placed in such escrow account pending judicial review. If refunds made to policyholders are ordered under this subsection, the amounts refunded shall bear interest at the rate determined under this subsection. That rate, to be computed by the Bureau, shall be the average of the prime rates on the effective date of the filing and each anniversary of that date occurring prior to the date of the Commissioner's order requiring refunds, with the prime rate on each of the dates being the average of the prime rates of the four largest banking institutions domiciled in this State as of that date, plus three percent (3%). (1977, c. 828, s. 6; 1979, c. 824, s. 4; 1985 (Reg. Sess., 1986), c. 1027, ss. 3.1, 4; 1995, c. 517, s. 19.)

Editor's Note. — Session Laws 1995, c. 517, s. 41, contains a severability clause.

§ 58-36-30. Deviations.

(a) No insurer, officer, agent or representative thereof shall knowingly issue or deliver or knowingly permit the issuance or delivery of any policy of insurance in this State which does not conform to the rates, rating plans, classifications, schedules, rules and standards made and filed by the Bureau. However, an insurer may deviate from the rates promulgated by the Bureau provided the insurer has filed the deviation to be applied both with the Bureau and the Commissioner, and provided the deviation is uniform in its application to all risks in the State of the class to which the deviation is to apply; and provided such deviation is approved by the Commissioner. The Commissioner shall approve proposed deviations if they do not render the rates excessive, inadequate or unfairly discriminatory. If approved, the deviation may thereafter be amended, subject to the provisions of this subsection. The deviation may be terminated only if the deviation has been in effect for a period of six months before the effective date of the termination and the insurer notifies the Commissioner of the termination no later than 15 days before the effective date of the termination.

(b) A rate in excess of that promulgated by the Bureau may be charged by an insurer on any specific risk if the higher rate is charged in accordance with rules adopted by the Commissioner and with the knowledge and written consent of the insured. The insurer is not required to obtain the written consent of the insured on any renewal of or endorsement to the policy if the policy renewal or endorsement states that the rates are greater than those rates that are applicable in the State of North Carolina. The insurer shall retain the signed consent form and other policy information for each insured and make this information available to the Commissioner, upon request of the Commissioner. This subsection may be used to provide motor vehicle liability coverage limits above those required under Article 9A of Chapter 20 of the General Statutes and above those cedable to the Facility under Article 37 of this Chapter to persons whose personal excess liability insurance policies require that they maintain specific higher liability coverage limits. Any data obtained by the Commissioner under this subsection is proprietary and confidential and is not a public record under G.S. 132-1 or G.S. 58-2-100.

(c) Any deviation with respect to workers' compensation and employers' liability insurance written in connection therewith as filed under subsection (a) of this section shall apply uniformly to all classifications. Any approved rate under subsection (b) of this section with respect to workers' compensation and employers' liability insurance written in connection therewith shall be furnished to the Bureau.

(d) Notwithstanding any other provision of law prohibiting insurance rate differentials based on age, with respect to nonfleet private passenger motor vehicle insurance under the jurisdiction of the Bureau, any member of the Bureau may apply for and use in this State, subject to the Commissioner's approval, a downward deviation in the rates for insureds who are 55 years of age or older. (1977, c. 828, s. 6; 1983, c. 162, ss. 1, 2; 1985, c. 666, s. 1; 1987, c. 869, s. 1; 1993, c. 409, s. 25; 1995, c. 517, ss. 20, 21; 1995 (Reg. Sess., 1996), c. 668, s. 1.)

Editor's Note. — Session Laws 1995, c. 517, s. 41, contains a severability clause.

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective October 1, 1996, and applicable to policies issued or renewed on or after that date, in subsection (a), in the second sentence, deleted "said" following "Commissioner, and provided the", and substituted "the" for "such" following "State of the class to which", substituted "they" for "the same" in the third sentence, and substituted "has" for "will have " in the last sentence; and in subsection (b), in the first sentence, added "by an insurer", substituted "if the" for "provided such", and substituted "in accordance with rules adopted by the Commissioner" for "the approval of the Commissioner", added the second and third sentences, and substituted "Any data obtained by the Commissioner under this subsection is proprietary and confidential and is not a public record" for "All data filed with the Commissioner under this subsection are proprietary and confidential and are not public records" in the last sentence.

§ 58-36-70. Rate filings and hearings for motor vehicle insurance.

Editor's Note. —

Session Laws 1995, c. 507, s. 11A(c), amended Session Laws 1989 (Reg. Sess., 1990), c. 1069, s. 31, deleting the last sentence regarding the expiration of amendments to the General Statutes by Session Laws 1989 (Reg. Sess., 1990), c. 1069, if the legislature did not appropriate or transfer funds. Session Laws 1989 (Reg. Sess., 1990), s. 31, as amended by Session Laws 1995, c. 507, s. 11A(c), provides: "Section 23 [see § 58-36-70] of this act does not apply to the 1990 automobile rate filing made pursuant to Article 36 of Chapter 58 of the General Statutes. Section 27 [§ 143-3.6] of this act shall expire at the end of the 1993-1994 fiscal year and Section 28 [§ 143-3.7] shall become effective upon the expiration of Section 27."

Session Laws 1995, c. 507, s. 1.1, provides that that act shall be known and cited as the Expansion and Capital Improvements Appropriations Act of 1995.

Session Laws 1995, c. 507, s. 28.9, provides: "Except for statutory changes or other provisions that clearly indicate an intention to have effects beyond the 1995-97 fiscal biennium, the textual provisions of this act apply only to funds appropriated for, and activities occurring during, the 1995-97 biennium."

CASE NOTES

Cited in State ex rel. Comm'r of Ins. v. North Carolina Rate Bureau, 124 N.C. App. 674, 478 S.E.2d 794 (1996).

§ 58-36-75. At-fault accidents and certain moving traffic violations under the Safe Driver Incentive Plan.

(a) The subclassification plan promulgated pursuant to G.S. 58-36-65(b) may provide for separate surcharges for major, intermediate, and minor accidents. A "major accident" is an at-fault accident that results in either (i) bodily injury or death or (ii) only property damage of two thousand five hundred dollars ($2,500) or more. An "intermediate accident" is an at-fault accident that results in only property damage of more than one thousand five hundred dollars ($1,500) but less than two thousand five hundred dollars ($2,500). A "minor accident" is an at-fault accident that results in only property damage of one thousand five hundred dollars ($1,500) or less. The subclassification plan may also exempt certain minor accidents from the Facility recoupment surcharge. The Bureau shall assign varying Safe Driver Incentive Plan point values and surcharges for bodily injury in at-fault accidents that are commensurate with the severity of the injury, provided that the point value and surcharge assigned for the most severe bodily injury shall not exceed the point value and surcharge assigned to a major accident involving only property damage.

(a1) The subclassification plan shall provide that there shall be no premium surcharge, increase in premium on account of cession to the Reinsurance Facility, or assessment of points against an insured where: (i) the insured is involved and is at fault in a "minor accident," as defined in subsection (a) of this section; (ii) the insured is not convicted of a moving traffic violation in connection with the accident; (iii) neither the vehicle owner, principal operator, nor any licensed operator in the owner's household has a driving record consisting of one or more convictions for a moving traffic violation or one or more at-fault accidents during the three-year period immediately preceding the date of the application for a policy or the date of the preparation of the renewal of a policy; and (iv) the insured has been covered by liability insurance with the same company or company group continuously for at least the six months immediately preceding the accident. Notwithstanding (iv) of this subsection, if the insured has been covered by liability insurance with the same company or company group for at least six continuous months, some or all of which were after the accident, the insurance company shall remove any premium surcharge or assessment of points against the insured if requirements (i), (ii), and (iii) of this subsection are met. Also notwithstanding (iv) of this subsection, an insurance company may choose not to assess a premium surcharge or points against an insured who has been covered by liability insurance with that company or with the company's group for less than six months immediately preceding the accident, if requirements (i), (ii), and (iii) are met.

(a2) The subclassification plan shall provide that there shall be no premium surcharge or assessment of points against an insured where (i) the insured's driver's license has been revoked under G.S. 20-16.5; and (ii) the insured is subsequently acquitted of the offense involving impaired driving, as defined in G.S. 20-4.01(24a), that is related to the revocation, or the charge for that offense is dismissed. In addition, no insurer shall use, for rating, underwriting, or classification purposes, including ceding any risk to the Facility or writing any kind of coverage subject to this Article, any license revocation under G.S. 20-16.5 if the insured is acquitted or the charge is dismissed as described in this subsection.

(b) The subclassification plan promulgated pursuant to G.S. 58-36-65(b) shall provide that with respect to a conviction for any moving traffic violation that is not listed in subsection (c) of this section, there shall be no Motor Vehicle Reinsurance Facility recoupment surcharge pursuant to G.S. 58-37-40(f) unless (i) the vehicle owner, principal operator, or any licensed operator in the owner's household has a driving record consisting of one or more convictions for a moving traffic violation, other than the conviction for the exempt violation, or one or more at-fault accidents during the three-year period immediately preceding the date of the application for a policy or the date of the preparation of the renewal of a policy, or (ii) the moving traffic violation for which the operator has been convicted occurred at the time of an accident for which he was at fault. Nothing in this section affects any provisions in the subclassification plan for premium surcharges for moving traffic violations or at-fault accidents.

(c) The subclassification plan promulgated pursuant to G.S. 58-36-65(b) shall provide for facility recoupment surcharges pursuant to G.S. 58-37-40(f) and G.S. 58-37-75, in addition to premium surcharges, for convictions for the following moving traffic violations:

General Statute	Description of Offense
20-12.1	Being impaired while accompanying a permittee who is learning to drive
20-28	Driving while license is suspended or revoked
20-138.1	Driving a vehicle while impaired
20-138.2	Driving a commercial vehicle while impaired
20-138.3	Driving by provisional licensee after consuming alcohol or drugs
20-140(a)	Driving carelessly and heedlessly in willful or wanton disregard of the rights of others
20-140(b)	Driving without due caution in a manner so as to endanger other people or property
20-141(a)	Only driving at least 11 miles per hour over the posted speed limit
20-141(j1)	Driving more than 15 mph over legal limit
20-141.1	Speeding in a school zone
20-141.3(a)	Engaging in prearranged speed competition with another motor vehicle
20-141.3(b)	Willfully engaging in speed competition with another motor vehicle (not prearranged)
20-141.3(c)	Allowing or authorizing others to use one's motor vehicle in prearranged speed competition or placing or receiving a bet or wager on a prearranged speed competition
20-141.4(a1)	Death by vehicle (unintentionally causing death of another while engaged in impaired driving)
20-141.4(a2)	Death by vehicle (unintentionally causing death of another as a result of a violation of motor vehicle law intended to regulate traffic or used to control operation of a vehicle)

General Statute	Description of Offense
20-141.5	Speeding while fleeing or attempting to elude arrest
20-166(a)	Failure to stop by driver who knew or should have known he was involved in accident and that accident caused death or injury to any person
20-166(c)	Failure of driver involved in accident causing property damage or personal injury or death (if driver did not know of injury or death) to stop at scene of accident
20-175.2	Failure to yield right-of-way to blind person at crossings, intersections, and traffic control signal points
20-217	Failure to stop and remain stopped when approaching a stopped school bus engaged in receiving or discharging passengers and while bus has mechanical stop signal displayed
14-18	Voluntary manslaughter
14-18	Involuntary manslaughter

(d) There shall be no Facility recoupment surcharge under G.S. 58-37-40(f) or Safe Driver Incentive Plan surcharges under G.S. 58-36-65 for accidents occurring when only operating a firefighting, rescue squad, or law enforcement vehicle in accordance with G.S. 20-125(b) and in response to an emergency if the operator of the vehicle at the time of the accident was a paid or volunteer member of any fire department, rescue squad, or any law enforcement agency. This exception does not include an accident occurring after the vehicle ceases to be used in response to the emergency and the emergency ceases to exist.

(e) There shall be no Facility recoupment surcharge under G.S. 58-37-40(f) for any accident involving only damage to the operator's vehicle or to the property of another for which full payment or compensation has been made by the operator at fault; and when the motor vehicle insurer of the operator has not made any payment under any kind of insurance policy for such property damage to or on behalf of such operator. Notwithstanding the provision of this subsection, an insured still has a duty to report such accident to his insurer and to law enforcement authorities if such duty is required by the insurance contract or by law.

(f) The subclassification plan shall provide that with respect to a conviction for a "violation of speeding 10 miles per hour or less over the speed limit" there shall be no premium surcharge nor any assessment of points unless there is a driving record consisting of a conviction or convictions for a moving traffic violation or violations, except for a prayer for judgment continued for any moving traffic violation, during the three years immediately preceding the date of application or the preparation of the renewal. The subclassification plan shall also provide that with respect to a prayer for judgment continued for any moving traffic violation, there shall be no premium surcharge nor any assessment of points unless the vehicle owner, principal operator, or any licensed operator in the owner's household has a driving record consisting of a prayer or prayers for judgment continued for any moving traffic violation or violations during the three years immediately preceding the date of application or the preparation of the renewal. For the purpose of this subsection, a "prayer for judgment continued" means a determination of guilt by a jury or a court though no sentence has been imposed. For the purpose of this subsection, a "violation of speeding 10 miles per hour or less over the speed limit" does not include the offense of speeding in a school zone in excess of the posted school zone speed limit.

(f1) The subclassification plan shall provide that in the event an insured is at fault in an accident and is convicted of a moving traffic violation in connection with the accident, only the higher plan premium surcharge between the accident and the conviction shall be assessed on the policy.

(g) As used in this section "conviction" means a conviction as defined in G.S. 20-279.1 and means an infraction as defined in G.S. 14-3.1. (1987, c. 869, s. 6; 1991, c. 101, s. 1; c. 713, s. 1; c. 720, s. 90; 1991 (Reg. Sess., 1992), c. 837, s. 11; c. 997, s. 1; 1993, c. 285, s. 11; 1995 (Reg. Sess., 1996), c. 730, s. 3; 1997-332, s. 1; 1997-443, s. 19.26(d).)

Editor's Note. —

Session Laws 1997-332, s. 2, provides that the North Carolina Rate Bureau shall amend the subclassification plan to implement the provisions of that act no later than October 1, 1997, that the amendments to the plan become effective January 1, 1998, and apply to at-fault accidents that occur on or after that date, and with respect to any at-fault accidents occurring prior to January 1, 1998, the surcharge and period for which the surcharge is applied and collected shall be determined by the subclassification plan in effect at the time the at-fault accident occurred.

Session Laws 1997-443, s. 1.1, provides: "This act shall be known as 'The Current Operations and Capital Improvements Appropriations Act of 1997'".

Session Laws 1997-443, s. 35.2, provides: "Except for statutory changes or other provisions that clearly indicate an intention to have effects beyond the 1997-99 fiscal biennium, the textual provisions of this act apply only to funds appropriated for, and activities occurring during, the 1997-99 fiscal biennium."

Session Laws 1997-443, s. 35.4, is a severability clause.

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective June 21, 1996, inserted "in accordance with G.S. 20-125(b) and" following "law enforcement vehicle" in the first sentence of subsection (d).

Session Laws 1997-332, s. 1, effective July 25, 1997, rewrote subsection (a).

Session Laws 1997-443, s. 19.26(d), effective December 1, 1997, and applicable to offenses committed on or after that date, in subsection (c) deleted "20-141(j)", deleted "Driving in excess of 55 mph and at least 15 mph over legal limit, while fleeing or attempting to elude arrest by a law enforcement officer", inserted "20-141.5", and inserted "Speeding while fleeing or attempting to elude arrest."

§ 58-36-85. Termination of a nonfleet private passenger motor vehicle insurance policy.

(a) Definitions. — The following definitions apply in this section:

(1) Policy. — A nonfleet private passenger motor vehicle liability insurance policy, including a policy that provides medical payments, uninsured motorist, or underinsured motor-

ist coverage, whose named insured is one individual or two or more individuals who reside in the same household.

(2) Terminate. — To cancel or refuse to renew a policy.

(b) Termination Restrictions. — An insurer shall not terminate a policy for a reason that is not specified in G.S. 58-37-50(1) through (5) or G.S. 58-36-65(g). A termination of a policy is not effective unless the insurer either has notified a named insured of the termination by sending a written termination notice by first class mail to the insured's last known address or is not required by this subsection to send a written termination notice. Proof of mailing of a written termination notice is proof that the notice was sent.

An insurer is not required to send a written termination notice if any of the following applies:

(1) The insurer has manifested its willingness to renew the policy by issuing or offering to issue a renewal policy, a certificate, or other evidence of renewal.

(2) The insurer has manifested its willingness to renew the policy by any means not described in subdivision (1) of this subsection, including mailing a premium notice or expiration notice by first class mail to the named insured and the failure of the insured to pay the required premium on or before the premium due date.

(3) A named insured has given written notification to the insurer or its agent that the named insured wants the policy to be terminated.

(c) Contents of Notice. — The form of a written termination notice used by an insurer must be approved by the Commissioner before it is used. A written termination notice must state the reason for the termination and the date the termination is effective. If the policy is terminated for nonpayment of the premium, the effective date may be 15 days from the date the notice is mailed. If the policy is terminated for any other reason, the effective date must be at least 60 days after the notice is mailed. A written termination notice must include or be accompanied by a statement that advises the insured of the penalty for driving a vehicle without complying with Article 13 of Chapter 20 of the General Statutes and that the insured has the right to request the Department to review the termination.

(d) Request for Review. — An insured who receives from an insurer a written termination notice may obtain review of the termination by filing with the Department a written request for review within 10 days after receiving a termination notice that complies with subsection (c) of this section. An insured who does not file a request within the required time waives the right to a review.

(e) Administrative Review. — When the Department receives a written request to review a termination, it must investigate and determine the reason for the termination. The Department shall issue a letter requiring one of the following upon completing its review:

(1) Approval of the termination, if it finds the termination complies with the law.

(2) Renewal or reinstatement of the policy, if it finds the termination does not comply with the law.

(3) Renewal or reinstatement of the policy and payment by the insurer of the costs of the Department's review, not to exceed one thousand dollars ($1,000), if it finds the termination does not comply with the law and the insurer willfully violated this section.

The Department shall mail the letter to the insured and the insurer. An insured or an insurer who disagrees with the determination of the Department in the letter may file a petition for a contested case under Article 3A of Chapter 150B of the General Statutes and the rules adopted by the Commissioner to implement that Article. The petition must be filed within 30 days after receiving the copy of the letter.

(f) Delegation. — The Commissioner shall designate an employee or a deputy to conduct the departmental review of a termination. The Commissioner may designate a deputy to conduct a contested case hearing concerning a termination. The Commissioner may not designate a deputy who conducted the departmental review of a termination to conduct a contested case hearing concerning the same termination.

(g) Effect of Review on Policy. — A policy shall remain in effect during administrative and judicial review of an insurer's action to terminate the policy.

(h) Liability Limit. — There is no liability on the part of and no cause of action for defamation or invasion of privacy arises against an insurer, an insurer's authorized representatives, agents, or employees, or a licensed insurance agent or broker for a communication or statement made concerning a written notice of termination.

(i) Records. — An insurer shall keep a record of a termination for three years. (1993 (Reg. Sess., 1994), c. 761, s. 30; 1995, c. 517, s. 22.)

Editor's Note. —
Session Laws 1995, c. 517, s. 41, contains a severability clause.

CASE NOTES

Nonrenewal for Nonpayment of Premiums. —
By sending a "Premium Notice" to insured, insurance company manifested its willingness to renew the policy and the failure to pay the premium by the due date was a termination of the policy by the insured not by the insurer. Zenns v. Hartford Accident & Indem. Co., 115 N.C. App. 482, 444 S.E.2d 692, cert. denied, 337 N.C. 699, 448 S.E.2d 541 (1994).

Notice in Premium Notice Required. — Where the premium notice neither expressly informed plaintiff that his policy was about to expire nor apprised him of the date of expiration, the notice was simply a statement of an account that will be due on the date indicated and failed to constitute a manifestation of the insurance company's willingness to renew within the meaning of subsection (g). Hales v. North Carolina Ins. Guar. Ass'n, 337 N.C. 329, 445 S.E.2d 590 (1994).

A Policy Continues After Expiration Until Notice Is Given. —
In order to cancel a policy the carrier must comply with the procedural requirements of the statute or the attempt at cancellation fails and the policy will continue in effect despite the insured's failure to pay in full the required premium. Hales v. North Carolina Ins. Guar. Ass'n, 337 N.C. 329, 445 S.E.2d 590 (1994).

§ 58-36-100. Prospective loss costs filings and final rate filings for workers' compensation and employers' liability insurance.

(a) Nothing in this section requires the Bureau or its member insurers to refile rates previously implemented before two years after the effective date of this section. Any member insurer of the

Bureau may continue to use all rates and deviations filed and approved for its use until disapproved, or the insurer makes its own filing to change its rates, either by making an independent filing or by filing a reference filing adoption form adopting the Bureau's prospective loss costs, or modification thereof. Except as provided in subsection (m) of this section, with the initial prospective loss costs reference filing, the Bureau shall no longer develop or file any minimum premiums, minimum premium formulas, or expense constants. If an insurer wishes to amend minimum premium formulas, it must file the minimum premium rules, formulas, or amounts it proposes to use.

(b) Definitions. As used in this section, the following terms have the following meanings:

(1) "Expenses". — That portion of a rate attributable to acquisition, field supervision, collection expenses, general expenses, as determined by the insurer.

(2) "Developed losses". — Losses (including loss adjustment expenses) adjusted, using standard actuarial techniques, to eliminate the effect of differences between current payment or reserve estimates and those needed to provide actual ultimate loss (including loss adjustment expense) payments.

(3) "Insurer". — A member insurer or group.

(4) "Loss trending". — Any procedure for projecting developed losses to the average date of loss for the period during which the policies are to be effective.

(5) "Multiplier". — An insurer's determination of the expenses, other than loss expense and loss adjustment expense, associated with writing workers' compensation and employers' liability insurance, which shall be expressed as a single nonintegral number to be applied equally and uniformly to the prospective loss costs approved by the Commissioner in making rates for each classification of risks utilized by that insurer.

(6) "Prospective loss costs". — That portion of a rate that does not include provisions for expenses (other than loss adjustment expenses) or profit; and that are based on historical aggregate losses and loss adjustment expenses adjusted through development to their ultimate value and projected through trending to a future point in time.

(7) "Rate". — The cost of insurance per exposure unit, whether expressed as a single number or as a prospective loss cost with an adjustment to account for the treatment of expenses, profit, and variations in loss experience, prior to any application of individual risk variations based on loss or expense considerations, and does not include minimum premiums.

(8) "Supplementary rating information". — Includes any manual or plan of rates, classification, rating schedule, minimum premium, policy fee, rating rule, rate-related underwriting rule, experience rating plan, statistical plan and any other similar information needed to determine the applicable rate in effect or to be in effect.

(c) Except as provided in subsection (m) of this section, for workers' compensation and employers' liability insurance written in connection with workers' compensation insurance, the Bureau shall no longer develop or file advisory final rates that contain provisions for expenses (other than loss adjustment expenses) and profit. The Bureau shall instead develop and file for approval with the Commissioner, in accordance with this section, reference filings containing advisory prospective loss costs and the underlying loss data and other supporting statistical and actuarial information for any calculations or assumptions underlying these loss costs. Loss-based assessments, any tax levied by the State or any political subdivision of the State, licensing costs, and fees will be included in prospective loss costs.

(d) After a reference filing has been filed with the Commissioner and approved, the Bureau shall provide its member insurers with a copy of the approved reference filing. The Bureau may print and distribute manuals of prospective loss costs as well as rules and other supplementary rating information described in subsection (k) of this section.

(e) Each insurer shall independently and individually determine the final rates it will file and the effective date of any rate changes. If an insurer decides to use the prospective loss costs in the approved reference filing in support of its own filing, the insurer shall make a filing using the reference filing adoption form. The insurer's rates shall be the combination of the prospective loss costs and the loss multiplier contained in the reference filing adoption form. Insurers may file modifications of the prospective loss costs in the approved reference filing based on their own anticipated experience. Supporting documentation is required for any upward or downward modifications of the prospective loss costs in the approved reference filing.

(f) The summary of supporting information form shall contain a reference to examples of how to apply an insurer's loss cost modification factor to the Bureau's prospective loss costs. Insurers may vary expense loads by individual classification or grouping. Insurers may use variable or fixed expense loads or a combination of these to establish their expense loadings. Each filing that varies the expense load by class shall specify the expense factor applicable to each class and shall include information supporting the justification for the variation. However, insurers shall file data in accordance with the uniform statistical plan approved by the Commissioner. Insurers may offer premium discount plans.

(g) An insurer may request to have its loss multiplier remain on file and reference all subsequent prospective loss costs reference filings. Upon receipt of subsequent approved Bureau reference filings, the insurer's rates shall be the combination of the prospective loss costs and the loss multiplier contained in the reference filing adoption form on file with the Commissioner, and will be effective on or after the effective date of the prospective loss costs. The insurer need not file anything further with the Commissioner. If an insurer that has filed to have its loss multiplier remain on file with the Department intends to delay, modify, or not adopt a particular Bureau reference filing, the insurer must make an appropriate filing with the Commissioner. The insurer's filed loss multiplier shall remain in effect until the insurer withdraws it or files a revised reference filing adoption form. The provisions of G.S. 58-40-20, 58-40-30, 58-40-35, and 58-40-45 apply to filings made by insurers under this section.

(h) An insurer may file such other information that the insurer considers relevant and shall provide such other information as may be requested by the Commissioner. When a filing is not accompanied by the information required under this section, the Commissioner shall inform the filer within 30 days after the initial filing that the filing is incomplete and describe what additional information is required. A filing is complete when the required information is furnished or when the filer certifies to the Commissioner that the additional information required by the Commissioner is not maintained or cannot be provided.

(i) To the extent that an insurer's final rates are determined solely by applying its loss multiplier, as presented in the reference filing adoption form, to the prospective loss costs contained in the Bureau's reference filing and printed in the Bureau's rating manual, the insurer need not develop or file its final rate pages with the Commissioner. If an insurer chooses to print and distribute final rate pages for its own use, based solely upon the application of its filed loss costs, the insurer need not file those pages with the Commissioner. If the Bureau does not print the loss costs in its manual, the insurer must submit its rates to the Commissioner.

(j) For reference filings filed by the Bureau:

(1) If the insurer has filed to have its loss multiplier remain on file, applicable to subsequent reference filings, and a new reference filing is filed and approved and if:

a. The insurer decides to use the revision of the prospective loss costs and effective date as filed, then the insurer does not file anything with the Commissioner. Rates are the combination of the prospective loss costs and the on-file loss multiplier and become effective on the effective date of the loss costs.

b. The insurer decides to use the prospective loss costs as filed but with a different effective date, then the insurer must notify the Commissioner of its effective date before the effective date of the loss costs.

c. The insurer decides to use the revision of the prospective loss costs, but wishes to change its loss multiplier, then the insurer must file a revised reference filing adoption form before the effective date of the reference filing.

d. The insurer decides not to revise its rates using the prospective loss costs, then the insurer must notify the Commissioner before the effective date of the loss costs.

(2) If an insurer has not elected to have its loss multiplier remain on file, applicable to future prospective loss costs reference filings, and a new reference filing is filed and approved, and if:

a. The insurer decides to use the prospective loss costs to revise its rates, then the insurer must file a reference filing adoption form including its effective date.

b. The insurer decides not to use the revisions, then the insurer does not file anything with the Commissioner.

(k) The Bureau shall file with the Commissioner, for approval, filings containing a revision of rules and supplementary rating information. This includes policy-writing rules, rating plans, classification codes and descriptions, and rules that include factors or relativities, such as employers' liability increased limits factors, classification relativities, or similar factors, but excludes minimum premiums. The Bureau may print and distribute manuals of rules and supplementary rating information, excluding minimum premiums.

(*l*) If a new filing of rules, relativities, and supplementary rating information is filed by the Bureau and approved and if:

(1) The insurer decides to use the revisions and effective date as filed together with the loss multiplier on file with the Commissioner, then the insurer shall not file anything with the Commissioner.

(2) The insurer decides to use the revisions as filed but with a different effective date, then the insurer must notify the Commissioner of its effective date before the approved Bureau filing's effective date.

(3) The insurer decides not to use the revision, then the insurer must notify the Commissioner before the Bureau filing's effective date.

(4) The insurer decides to use the revision with modifications, then the insurer must file the modification with the Commissioner, specifying the basis for the modification and the insurer's proposed effective date if different than the Bureau filing's effective date.

(m) The Bureau shall file all of the following with the Commissioner:

(1) Final workers' compensation rates and rating plans for the residual market.

(2) The uniform classification plan and rules.

(3) The uniform experience rating plan and rules.

(4) A uniform policy form to be used by member insurers for voluntary and residual market business.

(5) Advisory manual workers' compensation rates to be used for the sole purpose of computing the premium tax liability of self-insurers under G.S. 105-228.5.

(n) The rates filed under subdivision (m)(1) of this section shall be set at levels to self-fund the residual market, provide adequate premiums to pay losses and expenses, establish appropriate reserves, and provide a reasonable margin for underwriting profit and contingencies.

(o) Every insurer shall adhere to the uniform classification plan, experience rating plan, and policy form filed by the Bureau. (1995, c. 505, ss. 3-8.)

Editor's Note. — Session Laws 1995, c. 505, s. 11, made this section effective upon ratification. The act was ratified July 28, 1995.

Effect of Amendments. — Session Laws 1995, c. 505, which enacted this section, in ss. 4 through 8, effective September 1, 1997, deleted "for approval" following "must file" in the last sentence of subsection (a); in subsection (e), deleted "for approval" following "will file" in the first sentence, deleted "for approval" following "make a filing" in the second sentence, and deleted the last sentence regarding when a filing is deemed approved if not disapproved by the Commissioner; in subsection (g) deleted "and receives approval of" preceding "a revised reference" in the next to last sentence, and added the last sentence; in subsection (j) deleted "for approval" following "must file" in subdivision (j)(1)b., and deleted "for approval" following "adoption form" in subdivision (j)(2)a.; and deleted "for approval" following "Commissioner" in subdivision (*l*)(4).

ARTICLE 37.

North Carolina Motor Vehicle Reinsurance Facility.

§ 58-37-25. General obligations of insurers.

CASE NOTES

Use of Own Policy Forms Not Permitted. — An insurer writing automobile insurance in North Carolina is not permitted to use its own policy forms on insurance policies ceded to the Facility. St. Paul Fire & Marine Ins. Co. v. North Carolina Motor Vehicle Reinsurance Facility, 124 N.C. App. 450, 476 S.E.2d 897 (1996).

As the legislature has specifically stated in another statute that policy forms are to be determined by the Facility, and the more specific statute prevails, there is no violation of the antidiscrimination provision of subsection (b) when the Facility mandates the uniform use of policy forms for all ceded motor vehicle insurance business. St. Paul Fire & Marine Ins. Co. v. North Carolina Motor Vehicle Reinsurance Facility, 124 N.C. App. 450, 476 S.E.2d 897 (1996).

§ 58-37-30. General obligations of agents.

(a) Except as otherwise provided in this Article, no licensed agent of an insurer authorized to solicit and accept premiums for motor vehicle insurance or any component thereof by the company he represents shall refuse on behalf of said company to accept any application from an eligible risk for such insurance and to immediately bind the coverage applied for and for a period of not less than six months if cession of the particular coverage and coverage limits applied for are permitted in the Facility, provided the application is submitted during the agent's normal business hours, at his customary place of business and in accordance with the agent's customary practices and procedures. The commission paid on the insurance coverages provided in this Article shall not be less than the commission on insurance coverage written through the North Carolina Insurance Plan on May 1, 1973. The same commission shall apply uniformly statewide.

(b) It shall be the responsibility of the agent to write the coverage applied for at what he believes to be the appropriate rate level. If coverage is written at the Facility rate level and the company elects not to cede, the policy shall be rated at a rate under Article 36 of this Chapter. Coverage written at a rate under Article 36 of this Chapter that is not acceptable to the company must either be placed with another company or rated at the Facility rate level by the agent. (1973, c. 818, s. 1; 1977, c. 828, s. 11; 1995, c. 517, s. 23.)

Editor's Note. — Session Laws 1995, c. 517, s. 41, contains a severability clause.

§ 58-37-35. The Facility; functions; administration.

CASE NOTES

Use of Own Policy Forms Prohibited. — An insurer writing automobile insurance in North Carolina is not permitted to use its own policy forms on insurance policies ceded to the Facility. St. Paul Fire & Marine Ins. Co. v. North Carolina Motor Vehicle Reinsurance Facility, 124 N.C. App. 450, 476 S.E.2d 897 (1996).

Subsection (l) is unambiguous in stating that insurers are required to use, in the writing of motor vehicle insurance policies ceded to the Facility, only those policy forms made by the Facility or those made by any licensed or statutory rating organization or bureau and filed with the Commissioner. St. Paul Fire & Marine Ins. Co. v. North Carolina Motor Vehicle Reinsurance Facility, 124 N.C. App. 450, 476 S.E.2d 897 (1996).

As the legislature has specifically stated in another statute that policy forms are to be determined by the Facility, and the more specific statute prevails, there is no violation of the antidiscrimination provision of § 58-37-25 (b) when the Facility mandates the uniform use of policy forms for all ceded motor vehicle insurance business. St. Paul Fire & Marine Ins. Co. v. North Carolina Motor Vehicle Reinsurance Facility, 124 N.C. App. 450, 476 S.E.2d 897 (1996).

§ 58-37-40. Plan of operation.

(a) Within 60 days after the initial organizational meeting, the Facility shall submit to the Commissioner, for his approval, a proposed plan of operation, consistent with the provisions of this Article, which shall provide for economical, fair and nondiscriminating administration and for the prompt and efficient provision of motor vehicle insurance to eligible risks. Should no plan be submitted within the aforesaid 60-day period, then the Commissioner of Insurance shall formulate and place into effect a plan consistent with the provisions of this Article.

(b) The plan of operation, unless sooner approved in writing, shall be deemed to meet the requirements of the Article if it is not disapproved by order of the Commissioner within 30 days from the date of filing. Prior to the disapproval of all or any part of the proposed plan of operation the Commissioner shall notify the Facility in what respect the plan of operation fails to meet the specific requirements of this Article. The Facility shall, within 30 days thereafter, submit for his approval a revised plan of operation which meets the specific requirements of this Article. In the event the Facility fails to submit a revised plan of operation which meets the specific requirements of this Article within the aforesaid 30-day period, the Commissioner shall enter an order accordingly and shall immediately thereafter formulate and place into effect a plan consistent with the provisions of this Article.

(c) Any revision of the proposed plan of operation or any subsequent amendments to an approved plan of operation shall be subject to approval or disapproval by the Commissioner in the manner herein provided in subsection (b) with respect to the initial plan of operation.

(d) Any order of the Commissioner with respect to the plan of operation or any revision or amendment thereof shall be subject to court review as provided in G.S. 58-2-75.

(e) Upon approval of the Commissioner of the plan so submitted or promulgation of a plan deemed approved by the Commissioner, all insurance companies licensed to write motor vehicle insurance in this State or any component thereof as a prerequisite to further engaging in writing the insurance shall formally subscribe to and participate in the plan so approved.

The plan of operation shall provide for, among other matters, (i) the establishment of necessary facilities; (ii) the management of the Facility; (iii) the preliminary assessment of all members for initial expenses necessary to commence operations; (iv) the assessment of members if necessary to defray losses and expenses; (v) the distribution of gains to defray losses incurred since September 1, 1977; (vi) the distribution of gains by credit or reduction of recoupment or allocation surcharges to policies subject to recoupment or allocation surcharges pursuant to this Article (the Facility may apportion the distribution of gains among the coverages eligible for cession pursuant to this Article); (vii) the recoupment or allocation of losses sustained by the Facility since September 1, 1977, pursuant to this Article, which losses may be recouped by equitable pro rata assessment of member companies; (viii) the standard amount (one hundred percent (100%) or any equitable lesser amount) of coverage afforded on eligible risks which a member company may cede to the Facility; and (ix) the procedure by which reinsurance shall be accepted by the Facility. The plan shall further provide that:

(1) Members of the Board of Governors shall receive reimbursement from the Facility for their actual and necessary expenses incurred on Facility business, en route to perform Facility business, and while returning from Facility business plus a per diem allowance of twenty-five dollars ($25.00) a day which may be waived.

(2) In order to obtain a transfer of business to the Facility effective when the binder or policy or renewal thereof first becomes effective, the company must within 30 days of the binding or policy effective date notify the Facility of the identification of the insured, the coverage and limits afforded, classification data, and premium. The Facility shall accept risks at other times on receipt of necessary information, but acceptance shall not be retroactive. The Facility shall accept renewal business after the member on underwriting review elects to again cede the business.

(f) The plan of operation shall provide that every member shall, following payment of any pro rata assessment, commence recoupment of that assessment by way of a surcharge on motor vehicle insurance policies issued by the member or through the Facility until the assessment has been recouped. Such surcharge shall be a percentage of premium adopted by the Board of Governors of the Facility; and the charges determined on the basis of the surcharge shall be combined with and displayed as a part of the applicable premium charges. Provided, however, that recoupment of losses sustained by the Facility since September 1, 1977, with respect to nonfleet private passenger motor vehicles may be recouped only by surcharging policies (i) that are subject to the classification plan promulgated pursuant to G.S. 58-36-65 and (ii) to which one or more driving record points have been assigned pursuant to said plan, subject to the provisions of G.S. 58-36-75. If the amount collected during the period of surcharge exceeds assessments paid by the member to the Facility, the member shall pay over the excess to the Facility on a date specified by the Board of

Governors. If the amount collected during the period of surcharge is less than the assessments paid by the member to the Facility, the Facility shall pay the difference to the member. Except as hereinafter provided, the amount of recoupment shall not be considered or treated as a rate or premium for any purpose. The Board of Governors shall adopt and implement a plan for compensation of agents of Facility members when recoupment surcharges are imposed; such compensation shall not exceed the compensation or commission rate normally paid to the agent for the issuance or renewal of the automobile liability policy issued through the North Carolina Reinsurance Facility affected by such surcharge; provided, however, that the surcharge provided for in this section shall include an amount necessary to recover the amount of the assessment to member companies and the compensation paid by each member, pursuant to this section, to agents.

(g) The plan of operation shall provide that all investment income from the premium on business reinsured by the Facility shall be retained by or paid over to the Facility. In determining the cost of operation of the Facility, all investment income shall be taken into consideration.

(h) The plan of operation shall provide for audit of the annual statement of the Facility by independent auditor approved by the Legislative Services Commission.

(i) The Facility shall file with the Commissioner revisions in the Facility plan of operation for his approval or modification. Such revisions shall be made for the purpose of revising the classification and rating plans for other than nonfleet private passenger motor vehicle insurance ceded to the Facility. (1973, c. 818, s. 1; 1975, c. 19, s. 18; 1977, c. 828, ss. 20, 21; 1981, c. 590; c. 916, ss. 2, 3; 1985 (Reg. Sess., 1986), c. 1027, s. 34; 1987, c. 869, s. 5(1)—5(3); 1989, c. 424, s. 1; 1991, c. 720, s. 4; 1995, c. 517, s. 24.)

Editor's Note. — Session Laws 1995, c. 517, s. 41, contains a severability clause.

§ 58-37-65. Hearings; review.

CASE NOTES

Cited in St. Paul Fire & Marine Ins. Co. v. North Carolina Motor Vehicle Reinsurance Facility, 124 N.C. App. 450, 476 S.E.2d 897 (1996).

ARTICLE 39.

Insurance Information and Privacy Protection Act.

§ 58-39-75. Disclosure limitations and conditions.

An insurance institution, agent, or insurance-support organization shall not disclose any personal or privileged information about an individual collected or received in connection with an insurance transaction unless the disclosure is:

(1) With the written authorization of the individual, provided:
    a. If such authorization is submitted by another insurance institution, agent, or insurance-support organization,

the authorization meets the requirements of G.S. 58-39-35; or

b. If such authorization is submitted by a person other than an insurance institution, agent, or insurance-support organization, the authorization is:

1. Dated;
2. Signed by the individual; and
3. Obtained one year or less prior to the date a disclosure is sought pursuant to this paragraph; or

(2) To a person other than an insurance institution, agent, or insurance-support organization, provided such disclosure is reasonably necessary:

a. To enable such person to perform a business, professional, or insurance function for the disclosing insurance institution, agent, or insurance-support organization and such person agrees not to disclose the information further without the individual's written authorization unless the further disclosure:

1. Would otherwise be permitted by this section if made by an insurance institution, agent, or insurance-support organization; or
2. Is reasonably necessary for such person to perform its function for the disclosing insurance institution, agent, or insurance-support organization; or

b. To enable such person to provide information to the disclosing insurance institution, agent, or insurance-support organization for the purpose of:

1. Determining an individual's eligibility for an insurance benefit or payment; or
2. Detecting or preventing criminal activity, fraud, material misrepresentation, or material nondisclosure in connection with an insurance transaction; or

(3) To an insurance institution, agent, insurance-support organization, or self-insurer, provided the information disclosed is limited to that which is reasonably necessary:

a. To detect or prevent criminal activity, fraud, material misrepresentation, or material nondisclosure in connection with insurance transactions; or

b. For either the disclosing or receiving insurance institution, agent, or insurance-support organization to perform its function in connection with an insurance transaction involving the individual; or

(4) To a medical-care institution or medical professional for the purpose of (i) verifying insurance coverage or benefits, (ii) informing an individual of a medical problem of which the individual may not be aware, or (iii) conducting an operations or services audit, provided only such information is disclosed as is reasonably necessary to accomplish the foregoing purposes; or

(5) To an insurance regulatory authority; or

(6) To a law-enforcement or other government authority:

a. To protect the interests of the insurance institution, agent, or insurance-support organization in preventing or prosecuting the perpetration of fraud upon it; or

b. If the insurance institution, agent, or insurance-support organization reasonably believes that illegal activities have been conducted by the individual; or

(7) Otherwise permitted or required by law; or

(8) In response to a facially valid administrative or judicial order, including a search warrant or subpoena; or

(9) Made for the purpose of conducting actuarial or research studies, provided:
  a. No individual may be identified in any actuarial or research report;
  b. Materials allowing the individual to be identified are returned or destroyed as soon as they are no longer needed; and
  c. The actuarial or research organization agrees not to disclose the information unless the disclosure would otherwise be permitted by this section if made by an insurance institution, agent, or insurance-support organization; or

(10) To a party or a representative of a party to a proposed or consummated sale, transfer, merger, or consolidation of all or part of the business of the insurance institution, agent, or insurance-support organization, provided:
  a. Prior to the consummation of the sale, transfer, merger, or consolidation only such information is disclosed as is reasonably necessary to enable the recipient to make business decisions about the purchase, transfer, merger, or consolidation, and
  b. The recipient agrees not to disclose the information unless the disclosure would otherwise be permitted by this section if made by an insurance institution, agent or insurance-support organization; or

(11) To a person whose only use of such information will be in connection with the marketing of a product or service, provided:
  a. No medical-record information, privileged information, or personal information relating to an individual's character, personal habits, mode of living, or general reputation is disclosed, and no classification derived from such information is disclosed;
  b. The individual has been given an opportunity to indicate that he does not want personal information disclosed for marketing purposes and has given no indication that such individual does not want the information disclosed; and
  c. The person receiving such information agrees not to use it except in connection with the marketing of a product or service; or

(12) To an affiliate whose only use of the information will be in connection with an audit of the insurance institution or agent or the marketing of an insurance product or service, provided the affiliate agrees not to disclose the information for any other purpose or to unaffiliated persons; or

(13) By a consumer reporting agency, provided the disclosure is to a person other than an insurance institution or agent; or

(14) To a group policyholder for the purpose of reporting claims experience or conducting an audit of the insurance institution's or agent's operations or services, provided the information disclosed is reasonably necessary for the group policyholder to conduct the review or audit; or

(15) To a professional peer review organization for the purpose of reviewing the service or conduct of a medical-care institution or medical professional; or

(16) To a governmental authority for the purpose of determining the individual's eligibility for health benefits for which the governmental authority may be liable; or

(17) To a certificate holder or policyholder for the purpose of providing information regarding the status of an insurance transaction; or

(18) To a lienholder, mortgagee, assignee, lessor, or other person shown on the records of an insurance institution or agent as having a legal or beneficial interest in a policy of insurance; provided that the information disclosed is limited to that which is reasonably necessary to permit such person to protect its interest in such policy; or

(19) To authorized personnel of the Division of Motor Vehicles upon requests pursuant to G.S. 20-309(c) or G.S. 20-309(f).

(20) To the Department of Health and Human Services and the information disclosed is immunization information described in G.S. 130A-153. (1981, c. 846, s. 1; 1985, c. 666, s. 68; 1993, c. 134, s. 2; 1997-443, s. 11A.20A.)

Editor's Note. — Session Laws 1997-443, s. 1.1, provides: "This act shall be known as 'The Current Operations and Capital Improvements Appropriations Act of 1997'".

Session Laws 1997-443, s. 35.4, is a severability clause.

Effect of Amendments. — The 1997 amendment, effective August 28, 1997, substituted "Department of Health and Human Services" for "Department of Environment, Health, and Natural Resources" in subdivision (20).

ARTICLE 40.

Regulation of Insurance Rates.

§ 58-40-10. Other definitions.

As used in this Article and in Articles 36 and 37 of this Chapter:

(1) "Private passenger motor vehicle" means:

a. A motor vehicle of the private passenger or station wagon type that is owned or hired under a long-term contract by the policy named insured and that is neither used as a public or livery conveyance for passengers nor rented to others without a driver; or

b. A motor vehicle that is a pickup truck or van that is owned by an individual or by husband and wife or individuals who are residents of the same household if it:

1. Has a gross vehicle weight as specified by the manufacturer of less than 10,000 pounds; and
2. Is not used for the delivery or transportation of goods or materials unless such use is (i) incidental to the insured's business of installing, maintaining, or repairing furnishings or equipment, or (ii) for farming or ranching.

Such vehicles owned by a family farm copartnership or a family farm corporation shall be considered owned by an individual for the purposes of this section; or

c. A motorcycle, motorized scooter or other similar motorized vehicle not used for commercial purposes.

(2) "Nonfleet" motor vehicle means a motor vehicle not eligible for classification as a fleet vehicle for the reason that the motor vehicle is one of four or fewer motor vehicles hired under a long-term contract or owned by the insured named in the policy. (1987, c. 864, s. 67; 1989, c. 789, s. 1; 1995, c. 517, s. 25; 1995 (Reg. Sess., 1996), c. 730, s. 1.)

Editor's Note. — Session Laws 1995, c. 517, s. 41, contains a severability clause.

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective January 1, 1997, and applicable to policies written on or after that date, rewrote subdivision (2).

CASE NOTES

Private Passenger Motor Vehicle. — Low-boy trailer and Mack truck were not private passenger motor vehicles as they did not have a pickup body and were not delivery sedans nor panel trucks. Nationwide Mut. Ins. Co. v. Mabe, 342 N.C. 482, 467 S.E.2d 34 (1996).

"Nonfleet." — Fire vehicles listed in policy were private passenger vehicles not used in insured's business and hence "nonfleet" vehicles to which the exception to intrapolicy stacking of § 20-279.21(b)(4) as it read prior to 1991 did not apply. McCaskill v. Pennsylvania Nat'l Mut. Cas. Ins. Co., 118 N.C. App. 320, 454 S.E.2d 842 (1995).

Cited in Hendrickson v. Lee, 119 N.C. App. 444, 459 S.E.2d 275 (1995).

§ 58-40-15. Scope of application.

CASE NOTES

Cited in Harleysville Mut. Ins. Co. v. Packer, 60 F.3d 1116 (4th Cir. 1995).

§ 58-40-30. Filing of rates and supporting data.

(a) With the exception of inland marine insurance that is not written according to manual rates and rating plans, every admitted insurer and every licensed rating organization, which has been designated by any insurer for the filing of rates under G.S. 58-40-40, shall file with the Commissioner all rates and all changes and amendments thereto made by it for use in this State prior to the time they become effective.

(b) The Commissioner may require the filing of supporting data including:

(1) The experience and judgment of the filer, and to the extent the filer wishes or the Commissioner requires, of other insurers or rating organizations;

(2) The filer's interpretation of any statistical data relied upon; and

(3) Descriptions of the methods employed in setting the rates.

(c) Upon written consent of the insured stating the insured's reasons, a rate or deductible or both in excess of that provided by an otherwise applicable filing may be used on a specific risk, in accordance with rules adopted by the Commissioner. The insurer is not required to obtain the written consent of the insured on any renewal of or endorsement to the policy if the policy renewal or endorsement states that the rates or deductible, or both, are greater than those rates or deductibles, or both, that are applicable in the State of North Carolina. The insurer shall retain the signed consent form and other policy information for each insured and make this information available to the Commissioner, upon request of the Commissioner.

(d) This section and G.S. 58-41-50 shall be construed in pari materia. (1977, c. 828, s. 2; 1985 (Reg. Sess., 1986), c. 1027, s. 17; 1987, c. 441, s. 8; 1995 (Reg. Sess., 1996), c. 668, s. 2.)

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective October 1, 1996, and applicable to policies issued or renewed on or after that date, in subsection (c), in the first sentence, substituted "stating the insured's reasons" for "stating his reasons therefor", and substituted "in accordance with rules adopted by the Commissioner" for "provided that it is filed with the Commissioner in accordance with subsection (a) of this section", and added the second and third sentences.

§ 58-40-40. Delegation of rate making and rate filing obligation.

CASE NOTES

Cited in Hendrickson v. Lee, 119 N.C. App. 444, 459 S.E.2d 275 (1995).

§ 58-40-90. Examination of rating, joint underwriting, and joint reinsurance organizations.

The Commissioner shall, at least once every three years, make or cause to be made an examination of each rating organization licensed pursuant to G.S. 58-40-50 and each advisory organization licensed pursuant to G.S. 58-40-55. The Commissioner may, as often as deemed expedient, make or cause to be made, an examination of each group, association, or other organization referred to in G.S. 58-40-60. This examination shall relate only to the activities conducted pursuant to this Article and to the organizations licensed under this Article. The officers, manager, agents and employees of any such organization may be examined at any time under oath and shall exhibit all books, records, accounts, documents or agreements governing its method of operation. In lieu of any such examination, the Commissioner may accept the report of an examination made by the insurance advisory official of another state, pursuant to the laws of that state. (1977, c. 828, s. 2; 1995, c. 360, s. 2(b); 1995 (Reg. Sess., 1996), c. 742, s. 26.)

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective June 21, 1996, substituted "accounts" for "account" in the next-to-last sentence.

ARTICLE 41.

Insurance Regulatory Reform Act.

§ 58-41-50. Policy form and rate filings; punitive damages; data required to support filings.

(a) With the exception of inland marine insurance that is not written according to manual rates and rating plans, all policy forms must be filed with and either approved by the Commissioner or 90 days have elapsed and he has not disapproved the form before they may be used in this State. With respect to liability insurance policy forms, an insurer may exclude or limit coverage for punitive damages awarded against its insured.

(b) With the exception of inland marine insurance that is not written according to manual rates and rating plans, all rates or prospective loss cost multipliers by licensed fire and casualty companies or their designated rating organizations must be filed with the Commissioner at least 60 days before they may be used in this State. Any filing may become effective on a date earlier than that specified in this subsection upon agreement between the Commissioner and the filer.

(c) A filing that does not include the statistical and rating information required by subsections (d) and (e) of this section is not a proper filing, and will be returned to the filing insurer or organization. The filer may then remedy the defects in the filing. An otherwise defective filing thus remedied shall be deemed to be a proper filing, except that all periods of time specified in this Article will run from the date the Commissioner receives additional or amended documents necessary to remedy all material defects in the filing.

(d) The following information must be included in each policy form, rule, and rate filing:

(1) A detailed list of the rates, rules, and policy forms filed, accompanied by a list of those superseded; and

(2) A detailed description, properly referenced, of all changes in policy forms, rules, and rates, including the effect of each change.

(e) Each policy form, rule, and rate filing that is based on statistical data must be accompanied by the following properly identified information:

(1) North Carolina earned premiums at the actual and current rate level; losses and loss adjustment expenses, each on paid and incurred bases without trending or other modification for the experience period, including the loss ratio anticipated at the time the rates were promulgated for the experience period;

(2) Credibility factor development and application;

(3) Loss development factor derivation and application on both paid and incurred bases and in both numbers and dollars of claims;

(4) Trending factor development and application;

(5) Changes in premium base resulting from rating exposure trends;

(6) Limiting factor development and application;
(7) Overhead expense development and application of commission and brokerage, other acquisition expenses, general expenses, taxes, licenses, and fees;
(8) Percent rate change;
(9) Final proposed rates;
(10) Investment earnings, consisting of investment income and realized plus unrealized capital gains, from loss, loss expense, and unearned premium reserves;
(11) Identification of applicable statistical plans and programs and a certification of compliance with them;
(12) Investment earnings on capital and surplus;
(13) Level of capital and surplus needed to support premium writings without endangering the solvency of the company or companies involved; and
(14) Such other information that may be required by any rule adopted by the Commissioner.

Provided, however, that no filing may be returned or disapproved on the grounds that such information has not been furnished if the filer has not been required to collect such information pursuant to statistical plans or programs or to report such information to statistical agents, except where the Commissioner has given reasonable prior notice to the filer to begin collecting and reporting such information or except when the information is readily available to the filer.

(f) It is unlawful for an insurer to charge or collect, or attempt to charge or collect, any premium for insurance except in accordance with filings made with the Commissioner under this section and Article 40 of this Chapter.

(g) An insurer subject to this Article may develop and use an individual form or rate as a result of the uniqueness of a particular risk. The form or rate shall be developed, filed, and used in accordance with rules adopted by the Commissioner. (1985 (Reg. Sess., 1986), c. 1027, s. 14; 1987, c. 441, ss. 7, 9, 10; 1991, c. 644, s. 4; 1995, c. 193, s. 37.)

Editor's Note. — Session Laws 1995, c. 193, s. 67 contains a severability clause.

ARTICLE 42.

Mandatory or Voluntary Risk Sharing Plans.

§§ 58-42-1 through 58-42-55. Expired.

Editor's Note. — This Article expired by its own terms July 1, 1997.

ARTICLE 43.

General Regulations of Business—Fire Insurance.

§ 58-43-20: Repealed by Session Laws 1995 (Regular Session, 1996), c. 752, s. 1, effective June 21, 1996.

§ 58-43-40. (Expires January 1, 2000) Cancellation of fire insurance for buildings owned by religious organizations prohibited in certain circumstances.

(a) An insurer shall not cancel or decline to renew an insurance policy providing coverage for losses resulting from fire for a building owned by a religious organization solely because of:

(1) A previous occurrence of arson, unless the occurrence of arson was the act of a member of the religious organization that owns the building; or

(2) An oral or written statement directed to the religious organization or a member of the religious organization and threatening an act of arson against the religious organization.

This subsection applies only if:

(1) The religious organization reports all arson threats, arson attempts, or acts of arson to the appropriate law enforcement agency within 48 hours of discovery of such event and to the insurer not later than the second business day after the arson threat, arson attempt or act of arson is reported to the appropriate law enforcement agency; and

(2) The members of the religious organization fully cooperate with law enforcement and the insurer in any investigation of and the prosecution of all offenses related to, an arson threat, an arson attempt, or an act of arson.

(b) As a condition of insurance policy renewal or continuance, an insurer may require that a religious organization implement all reasonable mitigation, loss control, and fire control measures recommended by the local law enforcement agency, the local fire department, or the insurer.

(c) As used in this section, "religious organization" means any church, ecclesiastical, or denominational organization, or any organization that meets at an established physical place for worship in this State at which nonprofit religious services and activities are regularly conducted.

(d) The Commissioner may revoke, suspend, or refuse to renew the license of any insurer that violates this section pursuant to G.S. 58-3-100. (1997-438, s. 1.)

Editor's Note. — Session Laws 1997-438, s. 2, made this section effective October 1, 1997, and applicable to insurance policies issued or renewed on or after January 1, 1998, and provides that this section expires January 1, 2000.

ARTICLE 44.

Fire Insurance Policies.

§ 58-44-10: Repealed by Session Laws 1995, c. 517, s. 27, effective October 1, 1995.

Editor's Note. — Session Laws 1995, c. 517, s. 41 contains a severability clause.

§ 58-44-15. Fire insurance contract; standard policy provisions.

CASE NOTES

IV. Appraisal and Recovery.

IV. APPRAISAL AND RECOVERY.

The policy appraisal procedure is analogous to an arbitration proceeding; thus, errors of law or fact are insufficient to invalidate an award fairly and honestly made. Enzor v. North Carolina Farm Bureau Mut. Ins. Co., 123 N.C. App. 544, 473 S.E.2d 638 (1996).

Trial court did not err by failing to instruct the appraisers and umpire on the proper method for determining actual cash value. Enzor v. North Carolina Farm Bureau Mut. Ins. Co., 123 N.C. App. 544, 473 S.E.2d 638 (1996).

Appraisal procedure was not followed where report was signed only by the umpire as the umpire's signature alone failed to demonstrate that at least one other appraiser concurred in the award; thus, the appraisal award was invalid. Enzor v. North Carolina Farm Bureau Mut. Ins. Co., 123 N.C. App. 544, 473 S.E.2d 638 (1996).

§ 58-44-20. Standard policy; permissible variations.

CASE NOTES

Cited in Webster Enters., Inc. v. Selective Ins. Co., 125 N.C. App. 36, 479 S.E.2d 243 (1996).

ARTICLE 45.

Essential Property Insurance for Beach Area Property.

§ 58-45-1. Declarations and purpose of Article.

(a) It is hereby declared by the General Assembly of North Carolina that an adequate market for essential property insurance is necessary to the economic welfare of the beach and coastal areas of the State of North Carolina and that without such insurance the orderly growth and development of those areas would be severely impeded; that furthermore, adequate insurance upon property in the beach and coastal areas is necessary to enable homeowners and commercial owners to obtain financing for the purchase and improvement of their property; and that while the need for such insurance is increasing, the market for such insurance is not adequate and is likely to become less adequate in the future; and that the present plans to provide adequate insurance on property in the beach and coastal areas, while deserving praise, have not been sufficient to meet the needs of this area. It is further declared that the State has an obligation to provide an equitable method whereby every licensed insurer writing essential property insurance in North Carolina is required to meet its public responsibility instead of shifting the burden to a few willing and public-spirited insurers. It is the purpose of this Article to accept this obligation and to provide a mandatory program to assure an adequate market for essential property insurance in the beach and coastal areas of North Carolina.

(b) The General Assembly further declares that it is its intent in creating and, from time to time, amending this Article that the market provided by this Article not be the first market of choice, but the market of last resort. (1967, c. 1111, s. 1; 1969, c. 249; 1979, c. 601, s. 1; 1997-498, s. 9.)

Editor's Note. — Session Laws 1995 (Reg. Sess., 1996), c. 592, s. 3, provides in part that the directors of the North Carolina Insurance Underwriting Association (Beach Plan), along with the Department of Insurance, shall develop a plan to revise the participation formula of the Plan in a manner that encourages insurance companies to write voluntary policies in the beach area or other areas of the State and to write themselves out of the losses of the Plan, to apply to the 1997-98 fiscal year; further, the Department and Association shall determine the reasons insurance companies are not writing voluntary coverage on properties in the beach area of the State, considering that the companies may cede wind risks to the Association. The directors shall report to the Legislative Research Commission's Study Committee on the Insurance and Insurance-Related Issues on their findings ad the revised formula on or before October 1, 1996. Session Laws 1995 (Reg. Sess., 1996) c. 592, ss. 1 and 2 amended G.S. 58-45-25 and G.S. 58-45-5, respectively.

Session Laws 1995 (Reg. Sess., 1996), c. 579, s. 1, provides that the Department of Insurance and the the North Carolina Insurance Underwriting Association shall study the feasibility of and develop a proposal for a reserve fund to operate exclusively for the purpose of paying catastrophic losses incurred by wind risks insured under policies issued by the Association and for protecting and advancing the State's interest in maintaining insurance capacity in the State. The Department and the Association shall consult with the Internal Revenue Service for the purpose of making the fund exempt from federal taxation and may consider other options, including the purchase of reinsurance, in connection with establishment of the fund. The Department and the Association shall report to the Legislative Research Commission's Study Committee on Insurance and Insurance-Related Issues on any findings and recommendations on or before October 1, 1996, and shall report to the President Pro Tempore of the Senate and the Speaker of the House of Representatives on the proposal on or before March 1, 1997.

Session Laws 1997-498, s. 14, is a severability clause.

Session Laws 1997-498, s. 11, effective September 11, 1997, provides: "The Legislative Research Commission may study the provisions of Articles 45 and and 46 of Chapter 58 of the General Statutes, other relevant portions of the North Carolina General Statutes, and the plans and operations of the North Carolina Insurance Underwriting Association and the North Carolina Joint Underwriting Association. The Commission may consider all possible options to improve availability of property and homeowners insurance in the State. The Commission may report its findings and recommendations, along with legislation, to the 1998 Regular Session of the 1997 General Assembly and to the 1999 General Assembly."

Session Laws 1997-498, s. 12, effective September 11, 1997, provides: "The North Carolina Insurance Underwriting Association and the Commissioner of Insurance shall consider any further revisions necessary for the participation formulas of the Association for the purpose of encouraging insurance companies to voluntarily write property insurance policies in the beach and coastal areas of the State."

Effect of Amendments. — The 1997 amendment, effective January 1, 1998, added the subsection (a) designation, substituted "beach and coastal areas" for "beach area" throughout subsection (a), substituted "those areas" for "the beach area of the State of North Carolina" in the first sentence of subsection (a), and added subsection (b).

§ 58-45-5. Definition of terms.

As used in this Article, unless the context clearly otherwise requires:

(1) "Association" means the North Carolina Insurance Underwriting Association established under this Article;

(2) "Beach area" means all of that area of the State of North Carolina south and east of the inland waterway from the South Carolina line to Fort Macon (Beaufort Inlet); thence south and east of Core, Pamlico, Roanoke and Currituck sounds to the Virginia line, being those portions of land generally known as the Outer Banks;

(2a) "Coastal area" means all of that area of the State of North Carolina comprising the following counties: Beaufort, Brunswick, Camden, Carteret, Chowan, Craven, Currituck, Dare, Hyde, Jones, New Hanover, Onslow, Pamlico, Pasquotank, Pender, Perquimans, Tyrrell, and Washington. "Coastal area" does not include the portions of these counties that lie within the beach area.

(3) Repealed by Session Laws 1991, c. 720, s. 6.

(3a) "Crime insurance" means insurance against losses resulting from robbery, burglary, larceny, and similar crimes, as more specifically defined and limited in the various crime insurance policies, or their successor forms of coverage, approved by the Commissioner and issued by the Association. Such policies shall not be more restrictive than those issued under the Federal Crime Insurance Program authorized by Public Law 91-609.

(3b) "Directors" means the Board of Directors of the Association.

(4) "Essential property insurance" means insurance against direct loss to property as defined in the standard statutory fire policy and extended coverage, vandalism and malicious mischief endorsements thereon, or their successor forms of coverage, as approved by the Commissioner;

(5) "Insurable property" means real property at fixed locations in the beach and coastal area, including travel trailers when tied down at a fixed location, or the tangible personal property located therein, but shall not include insurance on motor vehicles; which property is determined by the Association, after inspection and under the criteria specified in the plan of operation, to be in an insurable condition. However, any one and two family dwellings built in substantial accordance with the Federal Manufactured Home Construction and Safety Standards, any predecessor or successor federal or State construction or safety standards, and any further construction or safety standards promulgated by the association and approved by the Commis-

sioner, or the North Carolina Uniform Residential Building Code and any structure or building built in substantial compliance with the North Carolina State Building Code, including the design-wind requirements, which is not otherwise rendered uninsurable by reason of use or occupancy, shall be an insurable risk within the meaning of this Article. However, none of the following factors shall be considered in determining insurable condition: neighborhood, area, location, environmental hazards beyond the control of the applicant or owner of the property. Also, any structure begun on or after January 1, 1970, not built in substantial compliance with the Federal Manufactured Home Construction and Safety Standards, any predecessor or successor federal or State construction or safety standards, and any further construction or safety standards promulgated by the association and approved by the Commissioner, or the North Carolina Uniform Residential Building Code or the North Carolina State Building Code, including the design-wind requirements therein, shall not be an insurable risk. The owner or applicant shall furnish with the application proof in the form of a certificate from a local building inspector, contractor, engineer or architect that the structure is built in substantial accordance with the Federal Manufactured Home Construction and Safety Standards, any predecessor or successor federal or State construction or safety standards, and any further construction or safety standards promulgated by the association and approved by the Commissioner, or the North Carolina Uniform Residential Building Code or the North Carolina State Building Code; however, an individual certificate shall not be necessary where the structure is located within a political subdivision which has certified to the Association on an annual basis that it is enforcing the North Carolina Uniform Residential Building Code or the North Carolina State Building Code and has no plans to discontinue enforcing these codes during that year.

(6) Repealed by Session Laws 1995 (Regular Session, 1996), c. 592, s. 2.

(6a) "Net direct premiums" means gross direct premiums (excluding reinsurance assumed and ceded) written on property in this State for essential property insurance, farmowners insurance, homeowners insurance, and the property portion of commercial multiple peril insurance policies as computed by the Commissioner, less:
a. Return premiums on uncancelled contracts;
b. Dividends paid or credited to policyholders; and
c. The unused or unabsorbed portion of premium deposits.

(7) "Plan of operation" or "plan" means the plan of operation of the Association approved or promulgated by the Commissioner under this Article. (1967, c. 1111, s. 1; 1969, c. 249; 1979, c. 601, ss. 2, 3; 1985, c. 516, s. 1; 1985 (Reg. Sess., 1986), c. 1027, ss. 21, 25; 1987 (Reg. Sess., 1988), c. 975, ss. 18, 19; 1991, c. 720, ss. 4, 6; 1991 (Reg. Sess., 1992), c. 784, s. 4; 1995 (Reg. Sess., 1996), c. 592, s. 2; 1997-498, s. 1.)

Editor's Note. — Session Laws 1997-498, s. 14, is a severability clause.

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective October 1, 1996, and applicable to policies issued or renewed on or after that date, repealed subdivision (6).

The 1997 amendment, effective September 11, 1997, inserted "As used" and "clearly" in the undesignated preliminary language, substituted "under" for "pursuant to the provisions of" in subdivision (1), added subdivisions (2a), (3b), and (6a), substituted "beach and coastal areas, including travel trailers when tied down at a fixed location" for "Beach area" in the first sentence of subdivision (5), deleted "or farm risks" following "motor vehicles" in that sentence, inserted "State" preceding "Building Code" throughout subdivision (5), and substituted "Commissioner under" for "Commissioner, pursuant to the provisions of" in subdivision (7).

§ 58-45-25. Each member of Association to participate in its expenses, profits, and losses.

(a) Each member of the Association shall participate in the expenses, profits, and losses of the Association in the proportion that its net direct premium written in this State during the preceding calendar year for residential and commercial properties outside of the beach and coastal areas bears to the aggregate net direct premiums written in this State during the preceding calendar year for residential and commercial properties outside of the beach and coastal areas by all members of the Association, as certified to the Association by the Commissioner. The Commissioner shall certify each member's participation after review of annual statements and any other reports and data necessary to determine participation and may obtain any necessary information or data from any member of the Association for this purpose. Any insurer that is authorized to write and that is engaged in writing any insurance, the writing of which requires the insurer to be a member of the Association under G.S. 58-45-10, shall become a member of the Association on the first day of January after authorization. The determination of the insurer's participation in the Association shall be made as of the date of membership of the insurer in the same manner as for all other members of the Association.

(b) All member companies shall receive credit each year for essential property insurance, farmowners insurance, homeowners insurance, and the property portion of commercial multiple peril policies voluntarily written in the beach and coastal areas in accordance with guidelines and procedures to be submitted by the Directors to the Commissioner for approval. The participation of each member company in the expenses, profits, and losses of the Association shall be reduced accordingly; provided, no credit shall be given where coverage for the peril of wind has been excluded. The guidelines and procedures for granting credit shall encourage and assist each member company to voluntarily write these coverages in the beach and coastal areas for commercial and residential properties.

(c) The North Carolina Insurance Underwriting Association shall use the "take out" program, as filed with the approved by the Commissioner, in the coastal area. (1967, c. 1111, s. 1; 1969, c. 249; 1991, c. 720, s. 58; 1995 (Reg. Sess., 1996), c. 592, s. 1; 1997-498, s. 2.)

Editor's Note. — Session Laws 1997-498, s. 13, was codified as subsection (c) of this section at the direction of the Revisor of Statutes. Subsection (c) became effective September 11, 1997.

Session Laws 1997-498, s. 14, is a severability clause.

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective October 1, 1996, and applicable to policies issued or renewed on or after that date, substituted "expenses, profits, and losses" for "writings, expenses, profits and losses in proportion to net direct premium of such member" in the catchline; and rewrote this section.

The 1997 amendment, effective January 1, 1998, rewrote this section.

§ 58-45-30. Directors to submit plan of operation to Commissioner; review and approval; amendments.

(a) The Directors shall submit to the Commissioner for his review and approval, a proposed plan of operation. The plan shall set forth the number, qualifications, terms of office, and manner of election of the members of the board of directors, and shall grant proper credit annually to each member of the Association for essential property insurance, farmowners, homeowners insurance, and the property portion of commercial multiple peril policies voluntarily written in the beach and coastal areas and shall provide for the efficient, economical, fair and nondiscriminatory administration of the Association and for the prompt and efficient provision of essential property insurance in the beach and coastal areas of North Carolina to promote orderly community development in those areas and to provide means for the adequate maintenance and improvement of the property in those areas. The plan may include the establishment of necessary facilities; management of the Association; the assessment of members to defray losses and expenses; underwriting standards; procedures for the acceptance and cession of reinsurance; procedures for determining the amounts of insurance to be provided to specific risks; time limits and procedures for processing applications for insurance; and any other provisions that are considered necessary by the Commissioner to carry out the purposes of this Article.

(b) The proposed plan shall be reviewed by the Commissioner and approved by him if he finds that such plan fulfills the purposes provided by G.S. 58-45-1. In the review of the proposed plan the Commissioner may, in his discretion, consult with the directors of the Association and may seek any further information which he deems necessary to his decision. If the Commissioner approves the proposed plan, he shall certify such approval to the directors and the plan shall become effective 10 days after such certification. If the Commissioner disapproves all or any part of the proposed plan of operation he shall return the same to the directors with his written statement for the reasons for disapproval and any recommendations he may wish to make. The directors may alter the plan in accordance with the Commissioner's recommendation or may within 30 days from the date of disapproval return a new plan to the Commissioner. Should the directors fail to submit a proposed plan of operation within 90 days of April 17, 1969, or a new plan which is acceptable to the Commissioner, or accept the recommendations of the Commissioner within 30 days after his disapproval of the plan, the Commissioner shall promulgate and place into effect a plan of operation certifying the same to the directors of the Association. Any such plan promulgated by the Commissioner shall take effect 10 days after certification to the directors: Provided, however, that until a plan of operation is in effect, pursuant to the provisions of this Article, any existing temporary placement facility may be continued in effect on a mandatory basis on such terms as the Commissioner may determine.

(c) The directors of the Association may, subject to the approval of the Commissioner, amend the plan of operation at any time. The Commissioner may review the plan of operation at any time the Commissioner deems expedient or prudent, but not less than once in each calendar year. After review of the plan the Commissioner may amend the plan after consultation with the directors and upon certification to the directors of the amendment.

(d) The Commissioner may designate the kinds of property insurance policies on principal residences to be offered by the association, including insurance policies under Article 36 of this Chapter, and the commission rates to be paid to agents or brokers for these policies, if the Commissioner finds, after a hearing held in accordance with G.S. 58-2-50, that the public interest requires the designation. The provisions of Chapter 150B do not apply to any procedure under this paragraph, except that G.S. 150B-39 and G.S. 150B-41 shall apply to a hearing under this paragraph. Within 30 days after the receipt of notification from the Commissioner of a change in designation pursuant to this paragraph, the association shall submit a revised plan and articles of association for approval in accordance with this section.

(e) The Association shall, subject to the Commissioner's approval or modification, provide in the plan of operation for coverage for appropriate classes of manufacturing risks.

(f) As used in this section, "plan of operation" includes all written rules, practices, and procedures of the Association, except for staffing and personnel matters. (1967, c. 1111, s. 1; 1969, c. 249; 1986, Ex. Sess., c. 7, s. 8; 1987, c. 731, s. 1; c. 864, s. 41; 1991, c. 720, s. 59; 1991 (Reg. Sess., 1992), c. 784, s. 5; 1997-498, s. 3.)

Editor's Note. — Session Laws 1997-498, s. 14, is a severability clause.

Effect of Amendments. — The 1997 amendment, effective January 1, 1998, in subsection (a), inserted "farmowners, homeowners insurance, and the property portion of commercial multiple peril policies" in the second sentence, substituted "beach and coastal areas" for "beach area" and for "beach areas" in that sentence, deleted "a preliminary assessment of all members for initial expenses necessary to the commencement of operation" following "plan may include" and "plan for" preceding "the assessment of members" in the last sentence, substituted "that are considered" for "as may be deemed" in that sentence, and made stylistic changes throughout.

§ 58-45-35. Persons eligible to apply to Association for coverage; contents of application.

(a) Any person having an insurable interest in insurable property, may, on or after the effective date of the plan of operation, be entitled to apply to the Association for such coverage and for an inspection of the property. A broker or agent authorized by the applicant may apply on the applicant's behalf. Each application shall contain a statement as to whether or not there are any unpaid premiums due from the applicant for essential property insurance on the property.

The term "insurable interest" as used in this subsection shall include any lawful and substantial economic interest in the safety or preservation of property from loss, destruction or pecuniary damage.

(b) If the Association determines that the property is insurable and that there is no unpaid premium due from the applicant for prior insurance on the property, the Association, upon receipt of the premium, or part of the premium, as is prescribed in the plan of operation, shall cause to be issued a policy of essential property insurance and shall offer additional extended coverage, optional perils endorsements, business income and extra expense coverage, crime insurance, separate policies of windstorm and hail insurance, or their successor forms of coverage, for a term of one year or three years. Short term policies may also be issued. Any policy issued under this section shall be renewed, upon application, as long as the property is insurable property.

(c) If the Association, for any reason, denies an application and refuses to cause to be issued an insurance policy on insurable property to any applicant or takes no action on an application within the time prescribed in the plan of operation, the applicant may appeal to the Commissioner and the Commissioner, or the Commissioner's designee from the Commissioner's staff, after reviewing the facts, may direct the Association to issue or cause to be issued an insurance policy to the applicant. In carrying out the Commissioner's duties under this section, the Commissioner may request, and the Association shall provide, any information the Commissioner deems necessary to a determination concerning the reason for the denial or delay of the application.

(d) An agent who is licensed under Article 33 of this Chapter as an agent of a company which is a member of the Association established under this Article shall not be deemed an agent of the Association.

(e) Policies of windstorm and hail insurance provided for in subsection (b) of this section are available only for risks in the beach and coastal areas for which essential property insurance has been written by licensed insurers. Whenever such other essential property insurance written by licensed insurers includes replacement cost coverage, the Association shall also offer replacement cost coverage. In order to be eligible for a policy of windstorm and hail insurance, the applicant shall provide the Association, along with the premium payment for the windstorm and hail insurance, a certificate that the essential property insurance is in force. The policy forms for windstorm and hail insurance shall be filed by the Association with the Commissioner for his approval before they may be used. Catastrophic losses, as determined by the Association and approved by the Commissioner, that are covered under the windstorm and hail coverage in the beach and coastal areas shall be adjusted by the licensed insurer that issued the essential property insurance and not by the Association. Expenses incurred by the licensed insurer in adjusting windstorm and hail losses shall be reimbursed by the Association. (1967, c. 1111, s. 1; 1969, c. 249; 1985, c. 516, s. 2; 1985 (Reg. Sess., 1986), c. 1027, s. 22; 1987, c. 421, ss. 1, 2; c. 629, s. 11; c. 864, s. 24; 1987 (Reg. Sess., 1988), c. 975, ss. 21-23; 1989, c. 376; c. 485, s. 26; 1991, c. 720, s. 25; 1991 (Reg. Sess., 1992), c. 784, s. 1; 1995, c. 517, s. 28; 1995 (Reg. Sess., 1996), c. 740, s. 1; 1997-498, ss. 5, 6.)

Editor's Note. — Session Laws 1995, c. 517, s. 41, contains a severability clause.

Session Laws 1997-498, s. 14, is a severability clause.

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective January 1, 1997, and applicable to policies issued or renewed on or after that date, inserted "business income coverage" in the first sentence of subsection (b).

Session Laws 1997-498, s. 5, effective September 11, 1997, inserted "and extra expense" in the first sentence of subsection (b) and inserted the second sentence of subsection (b).

Session Laws 1997-498, s. 6, effective January 1, 1998, inserted "in the beach and coastal areas" in the first sentence of subsection (e) and added the last two sentences of subsection (e).

§ 58-45-45. Rates, rating plans, rating rules, and forms applicable.

(a) Except as provided in subsection (b) of this section, the rates, rating plans, rating rules, and forms applicable to the insurance written by the Association shall be in accordance with the most recent manual rates or adjusted loss costs and forms that are legally in effect in the State. No special surcharge, other than those presently in effect, may be applied to the property insurance rates of properties located in the beach area.

(b) **(Effective until January 1, 2000)** The rates, rating plans, and rating rules for the separate policies of windstorm and hail insurance described in G.S. 58-45-35(b) shall be filed by the Association with the Commissioner for the Commissioner's approval, disapproval, or modification. The provisions of Articles 40 and 41 of this Chapter shall govern the filings. For windstorm and hail policies issued or renewed in the coastal area, unless otherwise determined by the Commissioner, the Association shall charge ninety percent (90%) of the approved windstorm and hail rates for the coastal area. Policy deductible plans, consistent with G.S. 58-45-1(b), may be filed by the Association with the Commissioner for the Commissioner's approval, disapproval, or modification.

(b) **(Effective January 1, 2000)** The rates, rating plans, and rating rules for the separate policies of windstorm and hail insurance described in G.S. 58-45-35(b) shall be filed by the Association with the Commissioner for the Commissioner's approval, disapproval, or modification. The provisions of Articles 40 and 41 of this Chapter shall govern the filings. Policy deductible plans, consistent with G.S. 58-45-1(b), may be filed by the Association with the Commissioner for the Commissioner's approval, disapproval, or modification. (1967, c. 1111, s. 1; 1969, c. 249; 1979, c. 601, s. 4; 1987 (Reg. Sess., 1988), c. 975, s. 24; 1991 (Reg. Sess., 1992), c. 784, s. 2; 1997-498, ss. 7, 8.)

Subsection (b) Set Out Twice. — The first version of subsection (b) set out above is effective until January 1, 2000. The second version of subsection (b) set out above is effective January 1, 2000.

Editor's Note. — Session Laws 1997-498, s. 14, is a severability clause.

Effect of Amendments. — Session Laws 1997-498, s. 7, effective January 1, 1998, added the last two sentences of subsection (b).

Session Laws 1997-498, s. 8, effective January 1, 2000, deleted the third sentence of subsection (b), relating to windstorm and hail policies.

§ 58-45-80. Premium taxes to be paid through Association.

All premium taxes due on insurance written under this Article shall be remitted by each insurer to the Association; and the Association, as collecting agent for its member companies, shall forward all such taxes to the Secretary of Revenue as provided in Article 8B of Chapter 105 of the General Statutes. (1985 (Reg. Sess., 1986), c. 928, s. 10; 1995 (Reg. Sess., 1996), c. 747, s. 12.)

Editor's Note. — Session Laws 1995 (Reg. Sess., 1996), c. 747, s. 16, provides: "This act does not obligate the General Assembly to appropriate funds."

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective January 1, 1997, deleted "to Commissioner" from the end of the catchline; and substituted "Secretary of Revenue" for "Commissioner".

ARTICLE 46.

Fair Access to Insurance Requirements.

§ 58-46-1. Purpose and geographic coverage of Article.

(a) It is the purpose of this Article to provide a program whereby adequate basic property insurance may be made available to property owners having insurable property in the State. It is further the purpose of this Article to encourage the improvement of properties located in the State and to arrest the decline of properties located in the State. It is the intent of the General Assembly in creating and, from time to time, amending this Article that the market provided by this Article not be the first market of choice, but the market of last resort.

(b) This Article shall apply to all geographic areas of the State except the "Beach Area" defined in G.S. 58-45-5(2).

(c) As used in this Article, "crime insurance" means insurance against losses resulting from robbery, burglary, larceny, and similar crimes, as more specifically defined and limited in the various crime insurance policies, or their successor forms of coverage, approved by the Commissioner and issued by the Association. Such policies shall not be more restrictive than those issued under the Federal Crime Insurance Program authorized by Public Law 91-609. (1969, c. 1284; 1985, c. 519, s. 1; 1986, Ex. Sess., c. 7, s. 4; 1985 (Reg. Sess., 1986), c. 1027, s. 24; 1987, c. 731, s. 1; 1987 (Reg. Sess., 1988), c. 975, s. 18; 1997-498, s. 10.)

Editor's Note. — Session Laws 1997-498, s. 14, is a severability clause.

Session Laws 1997-498, s. 11, effective September 11, 1997, provides: "The Legislative Research Commission may study the provisions of Articles 45 and and 46 of Chapter 58 of the General Statutes, other relevant portions of the North Carolina General Statutes, and the plans and operations of the North Carolina Insurance Underwriting Association and the North Carolina Joint Underwriting Association. The Commission may consider all possible options to improve availability of property and homeowners insurance in the State. The Commission may report its findings and recommendations, along with legislation, to the 1998 Regular Session of the 1997 General Assembly and to the 1999 General Assembly."

Session Laws 1997-498, s. 12, effective September 11, 1997, provides: "The North Carolina Insurance Underwriting

Association and the Commissioner of Insurance shall consider any further revisions necessary for the participation formulas of the Association for the purpose of encouraging insurance companies to voluntarily write property insurance policies in the beach and coastal areas of the State."

Effect of Amendments. — The 1997 amendment, effective January 1, 1998, added the last sentence of subsection (a).

§ 58-46-45. Premium taxes to be paid through Association.

All premium taxes due on insurance written under this Article shall be remitted by each insurer to the Association; and the Association, as collecting agent for its member companies, shall forward all such taxes to the Secretary of Revenue as provided in Article 8B of Chapter 105 of the General Statutes. (1985 (Reg. Sess., 1986), c. 928, s. 10; 1995 (Reg. Sess., 1996), c. 747, s. 13.)

Editor's Note. — Session Laws 1995 (Reg. Sess., 1996), c. 747, s. 16, provides: "This act does not obligate the General Assembly to appropriate funds."

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective January 1, 1997, deleted "to Commissioner" from the end of the catchline; and substituted "Secretary of Revenue" for "Commissioner".

ARTICLE 47.

Workers' Compensation Self-Insurance.

§§ 58-47-1 through 58-47-50: Repealed by Session Laws 1997-362, s. 2, effective December 1, 1997.

Part 1. Employer Groups.

§ 58-47-60. Definitions.

As used in this part:

(1) "Act" means the Workers" Compensation Act in Article 1 of Chapter 97 of the General Statutes, as amended.

(2) "Affiliate" has the same meaning as in G.S. 58-19-5(1).

(3) "Annual statement filing" means the most recent annual filing made with the Commissioner under G.S. 58-2-165.

(4) "Board" means the board of trustees or other governing body of a group.

(5) "Books and records" means all files, documents, and databases in a paper form, electronic medium, or both.

(6) "Control" means "control" as defined in G.S. 58-19-5(2).

(7) "GAAP financial statement" means a financial statement as defined by generally accepted accounting principles.

(8) "Group" means two or more employers who agree to pool their workers" compensation liabilities under the Act and are licensed under this Part.

(9) "Hazardous financial condition" means that, based on its present or reasonably anticipated financial condition, a person is insolvent or, although not financially impaired or insolvent, is unlikely to be able to meet obligations for known claims and reasonably anticipated claims or to pay other obligations in the normal course of business.

(10) "Member" means an employer that participates in a group.

(11) "Qualified actuary" means a member in good standing of the Casualty Actuarial Society or a member in good standing of the American Academy of Actuaries, who has been approved as qualified for signing casualty loss reserve opinions by the Casualty Practice Council of the American Academy of Actuaries, and is in compliance with G.S. 58-2-171.

(12) "Rate" means the cost of insurance per exposure unit, whether expressed as a single number or as a prospective loss cost with an adjustment to account for the treatment of expenses, profit, and variations in loss experience, before any application of individual risk variations based on loss or expense considerations, and does not include minimum premiums.

(13) "Service company" means an entity that has contracted with an employer or group for the purpose of providing any services related to claims adjustment, loss control, or both.

(14) "Third-party administrator" or "TPA" means a person engaged by a board to execute the policies established by the board and to provide day-to-day management of the group. "Third-party administrator" or "TPA" does not mean:
- a. An employer acting on behalf of its employees or the employees of one or more of its affiliates.
- b. An insurer that is licensed under this Chapter or that is acting as an insurer with respect to a policy lawfully issued and delivered by it and under the laws of a state in which the insurer is licensed to write insurance.
- c. An agent or broker who is licensed by the Commissioner under Article 33 of this Chapter whose activities are limited exclusively to the sale of insurance.
- d. An adjuster licensed by the Commissioner under Article 33 of this Chapter whose activities are limited to adjustment of claims.
- e. An individual who is an officer, a member, or an employee of a board.

(15) "Underwriting" means the process of selecting risks and classifying them according to their degrees of insurability so that the appropriate rates may be assigned. The process also includes rejection of those risks that do not qualify. (1997-362, s. 3.)

Editor's Note. — Session Laws 1997-362, s. 10, made this Part effective December 1, 1997.

Effect of Amendments. — The 1997 amendment, effective December 1, 1997, substituted "Workers' Compensation Self-Insurance" for "North Carolina Health Care Excess Liability Fund" as the Article heading.

§ 58-47-65. Licensing; qualification for approval.

(a) No group shall self-insure its workers" compensation liabilities under the Act unless it is licensed by the Commissioner under this Part.

(b) An applicant for a license shall file with the Commissioner the information required by subsection (f) of this section on a form prescribed by the Commissioner at least 90 days before the proposed licensing date. The applicant shall furnish to the Commissioner satisfactory proof of the proposed group's financial ability, through its members, to comply with the Act. No application is complete until the Commissioner has received all required information.

(c) The group shall comprise two or more employers who are members of and are sponsored by a single bona fide trade or professional association. The association shall (i) comprise members engaged in the same or substantially similar business or profession within the State, (ii) have been incorporated in North Carolina, (iii) have been in existence for at least five years before the date of application to the Commissioner to form a group, and (iv) submit a written determination from the Internal Revenue Service that it is exempt from taxation under 26 U.S.C. § 501(c). This subsection does not apply to a group that was organized and approved under North Carolina law before July 1, 1995.

(d) Only an applicant whose members' employee base is actuarially sufficient in numbers and provides an actuarially appropriate spreading of risk may apply for a license. The Commissioner shall consider (i) the financial strength and liquidity of the applicant relative to its ability to comply with the Act, (ii) the applicant's criteria and procedures regarding the review and monitoring of members' financial strength, (iii) reliability of the financial information, (iv) workers“ compensation loss history, (v) underwriting guidelines, (vi) claims administration, (vii) excess insurance or reinsurance, and (viii) access to excess insurance or reinsurance.

(e) Before issuing a license to any applicant, the Commissioner shall require, in addition to the other requirements provided by law, that the applicant file an affidavit signed by the association's board members that it has not violated any of the applicable provisions of this Part or the Act during the last 12 months, and that it accepts the provisions of this Part and the Act in return for the license.

(f) The license application shall comprise the following information:

(1) Biographical affidavits providing the education, prior occupation, business experience, and other supplementary information submitted for each promoter, incorporator, director, trustee, proposed management personnel, and other persons similarly situated.

(2) A forecast for a five-year period based on the initial capitalization of the proposed group and its plan of operation. The forecast shall be prepared by a certified public accountant, a qualified actuary, or both, be in sufficient detail for a complete analysis to be performed, and be accompanied by a list of the assumptions utilized in making the forecast.

(3) An individual application, under G.S. 58-47-125, of each member applying for coverage in the proposed group on the inception date of the proposed group, with a current GAAP financial statement of the member. The financial statements are confidential, but the Commissioner may use them in any judicial or administrative proceeding.

(4) A breakdown of all forecasted administrative expenses for the proposed group's fiscal year in a dollar amount and as a percentage of the estimated annual premium.

(5) The proposed group's procedures for evaluating the current and continuing financial strength of members.

(6) Evidence of the coverage required by G.S. 58-47-95.

(7) Demonstration provided by the board, satisfactory to the Commissioner, that the proposed group's member employee

base is actuarially sufficient in numbers and provides an actuarially appropriate spreading of risk.

(8) An assessment plan under G.S. 58-47-135(a).

(9) A listing of the estimated premium to be developed for each member individually and in total for the proposed group. Payroll data for each of the three preceding years shall be furnished by risk classification.

(10) An executed agreement by each member showing the member's obligation to pay to the proposed group not less than twenty-five percent (25%) of the member's estimated annual premium not later than the first day of coverage afforded by the proposed group.

(11) Composition of the initial board.

(12) An indemnity agreement on a form prescribed by the Commissioner.

(13) Proof, satisfactory to the Commissioner, that either the applicant has within its own organization ample facilities and competent personnel to service its program for underwriting, claims, and industrial safety engineering, or that the applicant will contract for any of these services. If the applicant is to perform any servicing, biographical affidavits of those persons who will be responsible for or performing servicing shall be included with the information in subdivision (1) of this subsection. If a group contracts with a service company or TPA to administer and adjust claims, the group shall provide proof of compliance with the other provisions of this Part.

(14) A letter stipulating the applicant's acceptance of membership in the North Carolina Self-Insurance Guaranty Association under Article 4 of Chapter 97 of the General Statutes.

(15) Any other specific information the Commissioner considers relevant to the organization of the proposed group.

(g) Every applicant shall execute and file with the Commissioner an agreement, as part of the application, in which the applicant agrees to deposit with the Commissioner cash or securities acceptable to the Commissioner. (1997-362, s. 3.)

§ 58-47-70. License denial; termination; revocation; restrictions.

(a) If the Commissioner denies a license, the Commissioner shall inform the applicant of the reasons for the denial. The Commissioner may issue a license to an applicant that remedies the reasons for a denial within 60 days after the Commissioner's notice. The Commissioner may grant additional time to an applicant to remedy any deficiencies in its application. A request for an extension of time shall be made in writing by the applicant within 30 days after the Commissioner's notice. If the applicant fails to remedy the reasons for the denial, the application shall be withdrawn or denied.

(b) A group shall not terminate its license or cease the writing of renewal business without obtaining prior written approval from the Commissioner. The Commissioner shall not grant the request of any group to terminate its license unless the group has closed or reinsured all of its incurred workers" compensation obligations and has settled all of its other legal obligations, including known and unknown claims and associated expenses.

(c) No group shall transfer its workers" compensation obligations under an assumption reinsurance agreement without complying with Part 2 of Article 10 of this Chapter.

(d) Every group is subject to Article 19 of this Chapter. No group shall merge with another group unless both groups are engaged in the same or a similar type of business. (1997-362, s. 3.)

§ 58-47-75. Reporting and records.

(a) As used in this section:

(1) "Audited financial report" has the same meaning as in the NAIC Model Rule Requiring Annual Audited Financial Reports, as specified in G.S. 58-2-205.

(2) "Duplicate record" means a counterpart produced by the same impression as the original record, or from the same matrix, or by mechanical or electronic rerecording or by chemical reproduction, or by equivalent techniques, such as imaging or image processing, that accurately reproduce the original record.

(3) "Original record" means the writing or recording itself or any counterpart intended to have the same effect by a person executing or issuing it, in the normal and ordinary course of business, or data stored in a computer or similar device, the printout or other output readable by sight, shown to reflect the data accurately. An "original" of a photograph includes the negative or any print from the negative.

(b) Each group shall file with the Commissioner the following:

(1) A statement in accordance with G.S. 58-2-165.

(2) An audited financial report.

(3) Annual payroll information within 90 days after the close of its fiscal year. The report shall summarize the payroll by annual amount paid and by classifications using the rules, classifications, and rates set forth in the most recently approved Workers" Compensation and Employers" Liability Insurance Manual governing audits of payrolls and adjustments of premiums. Each group shall maintain true and accurate payroll records. The payroll records shall be maintained to allow for verification of the completeness and accuracy of the annual payroll report.

(c) Each group shall make its financial statement and audited financial report available to its members upon request.

(d) All records shall be maintained by the group for the years during which an examination under G.S. 58-2-131 has not yet been completed.

(e) All records that are required to be maintained by this section shall be either original or duplicate records.

(f) If only duplicate records are maintained, the following requirements apply:

(1) The data shall be accessible to the Commissioner in legible form, and legible, reproduced copies shall be available.

(2) Before the destruction of any original records, the group in possession of the original records shall:

a. Verify that the records stored consist of all information contained in the original records, and that the original records can be reconstructed therefrom in a form acceptable to the Commissioner; and

b. Implement disaster preparedness or disaster recovery procedures that include provisions for the maintenance of duplicate records at an off-site location.

(3) Adequate controls shall be established with respect to the transfer and maintenance of data.

(g) Each group shall maintain its records under G.S. 58-7-50, G.S. 58-7-55, and the Act.

(h) All books of original entry and corporate records shall be retained by the group or its successor for a period of 15 years after the group ceases to exist. (1997-362, s. 3.)

§ 58-47-80. Assets and invested assets.

Funds shall be held and invested by the board under G.S. 58-7-160, 58-7-162, 58-7-163, 58-7-165, 58-7-167, 58-7-168, 58-7-170, 58-7-172, 58-7-173, 58-7-177, 58-7-178, 58-7-179, 58-7-180, 58-7-183, 58-7-185, 58-7-187, 58-7-188, 58-7-192, 58-7-193, 58-7-195, 58-7-197, and 58-7-200. (1997-362, s. 3.)

§ 58-47-85. Surplus requirements.

Every group shall maintain minimum surplus under one of the options in subdivision (1), (2), or (3) of this section:

(1) Maintain minimum surplus in accordance with Article 12 of this Chapter. A group organized and authorized before the effective date of this section shall comply with this section under the following schedule:

a. Forty percent (40%) of the surplus, in accordance with Article 12, by January 1, 1999.

b. Fifty-five percent (55%) of the surplus, in accordance with Article 12, by January 1, 2000.

c. Seventy percent (70%) of the surplus, in accordance with Article 12, by January 1, 2001.

d. Eighty-five percent (85%) of the surplus, in accordance with Article 12, by January 1, 2002.

e. One hundred percent (100%) of the surplus, in accordance with Article 12, by January 1, 2003.

The Commissioner shall not approve any dividend request that results in a surplus that is less than one hundred percent (100%) of the minimum surplus required by Article 12 of this Chapter.

(2) Maintain minimum surplus at an amount equal to ten percent (10%) of the group's total undiscounted outstanding claim liability, according to the group's annual statement filing, or such other amount as the Commissioner prescribes based on, but not limited to, the financial condition of the group and the risk retained by the group. In addition, the group shall:

a. Maintain specific excess insurance or reinsurance that provides the coverage limits in G.S. 58-47-95(a). The group shall retain no specific risk greater than five percent (5%) of the group's total annual earned premium according to the group's annual statement filing.

b. Maintain aggregate excess insurance or reinsurance with a coverage limit being the greater of two million dollars ($2,000,000) or twenty percent (20%) of the group's annual earned premium, according to the group's annual statement filing. The aggregate excess attachment point shall be one hundred ten percent (110%) of the annual earned premium, according to the group's annual statement filing. The required attachment point shall be reduced by each point, or fraction of a point, that a group's expense ratio exceeds thirty percent (30%). Conversely, the required attachment point may be increased by each point, or fraction of a point, that a group's expense ratio is less than thirty percent (30%), but in no event shall the attachment point be greater than one hundred fifteen percent (115%) of the annual earned premium.

c. Adopt a policy whereby every member:

1. Pays a deposit to the group of twenty-five percent (25%) of the member's estimated annual earned premium, or another amount that the Commissioner prescribes based on, but not limited to, the financial condition of the group and the risk retained by the group; or

2. Once every year files with the group the member's most recent year-end balance sheet, compiled by an independent certified public accountant. The balance sheet shall demonstrate that the member's financial position does not show a deficit equity and is appropriate for membership in the group. At the request of the Commissioner, the group shall make these filings available for review. These filings shall be kept confidential; provided that the Commissioner may use that information in any judicial or administrative proceeding.

(3) Maintain minimum surplus at an amount equal to three hundred thousand dollars ($300,000). The group shall immediately assess its members if, at any time, the group's surplus is less than the minimum surplus amount. In addition, the group shall maintain:

a. Specific excess insurance or reinsurance that provides coverage limits pursuant to G.S. 58-47-95(a). The group shall retain no specific risk greater than five percent (5%) of the group's total annual earned premium according to the group's annual statement filing.

b. Aggregate excess insurance or reinsurance with a coverage limit being the greater of two million dollars ($2,000,000) or twenty percent (20%) of the group's annual earned premium, according to the group's annual statement filing. The aggregate excess attachment point shall be one hundred ten percent (110%) of the annual earned premium, according to the group's annual statement filing. The required attachment point shall be reduced by each point, or fraction of a point, that a group's expense ratio exceeds thirty percent (30%). Conversely, the required attachment point may be increased by each point, or fraction of a point, that a group's expense ratio is less than thirty percent (30%), but in no event shall the attachment point be greater than one hundred fifteen percent (115%) of the annual earned premium.

The Commissioner may require different levels, or waive the requirement, of specific and aggregate excess loss coverage consistent with the market availability of excess loss coverage, the group's claims experience, and the group's financial condition. (1997-362, s. 3.)

§ 58-47-90. Deposits.

(a) Each group shall deposit with the Commissioner an amount equal to ten percent (10%) of the group's total annual earned premium, according to the group's annual statement filing, but not less than six hundred thousand dollars ($600,000), or another amount that the Commissioner prescribes based on, but not limited to, the financial condition of the group and the risk retained by the group.

(b) G.S. 58-5-1, 58-5-20, 58-5-25, 58-5-30, 58-5-35, 58-5-40, 58-5-63, 58-5-75, 58-5-80, 58-5-90(a) and (c), 58-5-95, 58-5-110, 58-5-115, and 58-5-120 apply to groups.

(c) A group organized and authorized before January 1, 1998, has until January 1, 2001, to comply with subsection (b) of this section. However, a dividend request shall not be approved by the Commissioner until the group has replaced its surety bonds with the deposit required by subsection (b) of this section.

(d) No judgment creditor, other than a claimant entitled to benefits under the Act, may levy upon any deposits made under this section.

(e) Surety bonds shall be in a form prescribed by the Commissioner and issued by an insurer authorized by the Commissioner to write surety business in North Carolina.

(f) Any surety bond may be exchanged or replaced with another surety bond that meets the requirements of this section if 90 days" advance written notice is provided to the Commissioner. An endorsement to a surety bond shall be filed with the Commissioner within 30 days after its effective date.

(g) If a group ceases to self-insure, dissolves, or transfers its workers' compensation obligations under an assumption reinsurance agreement, the Commissioner shall not release any deposits until the group has fully discharged all of its obligations under the Act. (1997-362, s. 3.)

§ 58-47-95. Excess insurance and reinsurance.

(a) Each group, on or before its effective date of operation and on a continuing basis thereafter, shall maintain specific and aggregate excess loss coverage through an insurance policy or reinsurance contract. Groups shall maintain limits and retentions commensurate with their exposures. A group's retention shall be the lowest retention suitable for groups with similar exposures and annual premium. The Commissioner may require different levels, or waive the requirement, of specific and aggregate excess loss coverage consistent with the market availability of excess loss coverage, the group's claims experience, and the group's financial condition.

(b) Any excess insurance policy or reinsurance contract under this section shall be issued by a licensed insurance company, an approved surplus lines insurance company, or an accredited reinsurer, and shall:

(1) Provide for at least 30 days' written notice of cancellation by certified mail, return receipt requested, to the group and to the Commissioner.

(2) Be renewable automatically at its expiration, except upon 30 days' written notice of nonrenewal by certified mail, return receipt requested, to the group and to the Commissioner.

(c) Every group shall provide to the Commissioner evidence of its excess insurance or reinsurance coverage, and any amendments, within 30 days after their effective dates. Every group shall, at the request of the Commissioner, furnish copies of any excess insurance policies or reinsurance contracts and any amendments. (1997-362, s. 3.)

§ 58-47-100. Examinations.

G.S. 58-2-131, 58-2-132, and 58-2-133 apply to groups. (1997-362, s. 3.)

§ 58-47-105. Dividends and other distributions.

(a) Group dividends and other distributions shall be made in accordance with G.S. 58-7-130, 58-8-25(b), and 58-19-30. A group shall be in compliance with this Part before payment of dividends or other distributions to its members. No group shall pay dividends or other distributions to its members until two years after the group's licensing date.

(b) Payment of dividends to the members of any group shall not be contingent upon the maintenance or continuance of membership in the group. (1997-362, s. 3.)

§ 58-47-110. Premium rates.

(a) As used in this section:

(1) "Bureau" means the North Carolina Rate Bureau in Article 36 of this Chapter.

(2) "Expenses" means that portion of a premium rate attributable to acquisition, field supervision, collection expenses, and general expenses, as determined by the group.

(3) "Multiplier" means a group's determination of the expenses, other than loss expense and loss adjustment expense, associated with writing workers" compensation and employers" liability insurance, which shall be expressed as a single nonintegral number to be applied equally and uniformly to the prospective loss costs approved by the Commissioner in making rates for each classification of risks utilized by that group.

(4) "Prospective loss costs" means that portion of a rate that does not include provisions for expenses (other than loss adjustment expenses) or profit and that is based on historical aggregate losses and loss adjustment expenses adjusted through development to their ultimate value and forecasted through trending to a future point in time.

(5) "Supplementary rating information" means any manual or plan of rates, classification, rating schedule, minimum premium, policy fee, rating rule, rate-related underwriting

rule, experience rating plan, statistical plan, and any other similar information needed to determine the applicable rate in effect or to be in effect.

(b) Rates and the effective date shall be submitted by the group to the Commissioner for prior approval in the form of a rate filing. The rate filing:

(1) Shall be on a form prescribed by the Commissioner and shall be supported by competent analysis, prepared by an actuary who is a member in good standing of the Casualty Actuarial Society or the American Academy of Actuaries, demonstrating that the resulting rates meet the standards of not being excessive, inadequate, or unfairly discriminatory;

(2) Shall have the final rates and the effective date determined independently and individually by the group;

(3) Shall have manual rates that are the combination of the prospective loss costs and the multiplier;

(4) Shall file any other information that the group considers relevant and shall provide any other information requested by the Commissioner;

(5) Shall be considered complete when the required information and all additional information requested by the Commissioner is received by the Commissioner. When a filing is not accompanied by the information required under this section, the Commissioner shall inform the group within 30 days after the initial filing that the filing is incomplete and shall note the deficiencies. If information required by a rate filing or requested by the Commissioner is not maintained or cannot be provided, the group shall certify that to the Commissioner;

(6) May include deviations to the prospective loss cost based on the group's anticipated experience. Sufficient documentation supporting the deviations and the impact of the deviation shall be included in the rate filing. Expense loads, whether variable, fixed, or a combination of variable and fixed, may vary by individual classification or grouping. Each filing that varies the expense load by class shall specify the expense factor applicable to each class and shall include information supporting the justification for the variation;

(7) Shall include any proposed use of a premium-sized discount program, a schedule rating program, a small deductible credit program or an expense constant or minimum premium, and the use shall be supported in the rate filing; and

(8) Shall be deemed approved, unless disapproved by the Commissioner in writing, within 60 days after the rate filing is made in its entirety. A group is not required to refile rates previously approved until two years after the effective date of this Part.

(c) At the time of the rate filing, a group may request to have its approved multiplier remain in effect and continue to use either the prospective loss cost filing in effect at the time of the rate filing or the prospective loss cost filing in effect at the time of the filing, along with all other subsequent prospective loss cost filings, as approved.

(d) To the extent that a group's manual rates are determined solely by applying its multiplier, as presented and approved in the rate filing, to the prospective loss costs contained in the Bureau's reference filing and printed in the Bureau's rating manual, the group need not develop or file its final rate pages with the Commissioner. If a group chooses to print and distribute final rate pages for its own use, based solely upon the application of its filed prospective loss costs, the group need not file those pages with the Commissioner. If the Bureau does not print the prospective loss costs in its manual, the group shall submit its rates to the Commissioner.

(e) If a new filing of rules, relativities, and supplementary rating information is filed by the Bureau and approved:

(1) The group shall not file anything with the Commissioner if the group decides to use the revisions as filed, with the effective date as filed together with the prospective loss multiplier on file with the Commissioner.

(2) The group shall notify the Commissioner of its effective date before the Bureau filing's effective date if the group decides to use the revisions as filed but with a different effective date.

(3) The group shall notify the Commissioner before the Bureau filing's effective date if the group decides not to use the revision or revisions.

(4) The group shall file the modification with the Commissioner, for approval, specifying the basis for the modification and the group's proposed effective date if different from the Bureau filing's effective date, if the group decides to use the revision with deviations.

(f) Every group shall adhere to the uniform classification plan and experience rating plan filed by the Bureau.

(g) Groups shall maintain data in accordance with the uniform statistical plan approved by the Commissioner.

(h) Each group shall submit annually a rate certification, signed by an actuary who is a member in good standing of the Casualty Actuarial Society or the American Academy of Actuaries, which states that the group's prospective rates are not excessive, inadequate, or unfairly discriminatory. The certification is to accompany the group's rate filing. If a rate filing is not required, the actuarial rate certification is to be submitted by the end of the calendar year. (1997-362, s. 3.)

§ 58-47-115. Premium payment requirements.

Groups shall collect members' premiums for each policy period in a manner so that at no time the sum of a member's premium payments is less than the total estimated earned premium for that member. (1997-362, s. 3.)

§ 58-47-120. Board; composition, powers, duties, and prohibitions.

(a) Each group shall be governed by a board or other governing body comprising no fewer than three persons, elected for stated terms of office, and subject to the Commissioner's approval. All board members shall be residents of this State or members of the group. At least two-thirds of the board shall comprise employees, officers, or directors of members; provided that the Commissioner may waive this requirement for good cause. The group's TPA, service company, or any owner, officer, employee, or agent of, or any other person affiliated with, the TPA or service company shall not serve as a board member. The board shall ensure that all claims are paid promptly and take all necessary precautions to safeguard the assets of the group.

(b) The board shall be responsible for the following:

(1) Maintaining minutes of its meetings and making the minutes available to the Commissioner.

(2) Providing for the execution of its policies, including providing for day-to-day management of the group and delineating in the minutes of its meetings the areas of authority it delegates.

(3) Designating a chair to facilitate communication between the group and the Commissioner.

(4) Adopting a policy of reimbursement from the assets of the group for out-of-pocket expenses incurred as board members, if so desired.

(c) The board shall not:

(1) Be compensated by the group, TPA, or service company except for out-of-pocket expenses incurred as board members.

(2) Extend credit to members for payment of a premium, except under payment requirements set forth in this Part.

(3) Borrow any money from the group or in the name of the group, except in the ordinary course of business, without first informing the Commissioner of the nature and purpose of the loan and obtaining the Commissioner's approval.

(d) The board shall adopt bylaws to govern the operation of the group. The bylaws shall comply with the provisions of this section and shall include:

(1) The method for selecting the board members, including terms of office.

(2) The method for amending the bylaws and the plans of operation and assessment.

(3) The method for establishing and maintaining the group.

(4) The procedures and requirements for dissolving the group.

(e) Each group shall file a copy of its bylaws with the Commissioner. Any changes to the bylaws shall be filed with the Commissioner no later than 30 days before their effective dates. The Commissioner may order the group to rescind or revoke any bylaw if it violates this section or any other applicable law or administrative rule.

(f) The board shall adopt and administer a plan of operation to assure the fair, reasonable, and equitable administration of the group. All members shall comply with the plan. The plan shall comply with this section and include:

(1) Procedures for administering the assets of the group.

(2) A plan of assessment.

(3) Loss control services to be provided to the members.

(4) Rules for payment and collection of premium.

(5) Basis for dividends.

(6) Reimbursement of board members.

(7) Intervals for meetings of the board, which shall be held at least semiannually.

(8) Procedures for the maintenance of records of all transactions of the group.

(9) Procedures for the selection of the board members.
(10) Additional provisions necessary or proper for the execution of the powers and duties of the group.
(11) Qualifications for group membership, including underwriting guidelines and procedures to identify members that are in hazardous financial conditions.

(g) The plan and any amendments become effective upon approval in writing by the Commissioner.

(h) Each year the board shall review:
(1) The performance evaluation of the TPA or service company, if applicable.
(2) Loss control services.
(3) Investment policies.
(4) Delinquent debts.
(5) Membership cancellation procedures.
(6) Admission of new members.
(7) Claims administration and reporting.
(8) Payroll audits and findings.
(9) Excess insurance or reinsurance coverage.

The board's findings from its review shall be documented in the board's minutes.

(i) G.S. 58-7-140 applies to board members. (1997-362, s. 3.)

§ 58-47-125. Admission and termination of group members.

(a) Prospective group members shall submit applications for membership to the board. The board, a designated employee of the group, or TPA shall approve an application for membership under the bylaws of the group. Members shall have bona fide offices in this State and members" employees shall be primarily engaged in business activities within this State. Members shall receive certificates of coverage from the board on a form acceptable to the Commissioner.

(b) The group shall make available to the Commissioner properly executed applications and indemnity agreements for all members, on forms prescribed by the Commissioner. If the applications and indemnity agreements are not executed properly and maintained, the Commissioner may order the group to cease writing all new business until all of the agreements are executed properly and obtained.

(c) Members may elect to terminate their participation in a group and may be canceled by the group under G.S. 97-99 and the bylaws of the group. (1997-362, s. 3.)

§ 58-47-130. Disclosure.

Every group through its board, TPA, service company, agents, or other representatives shall require, before accepting an application, each applicant for membership to acknowledge in writing that the applicant has received the following:
(1) A document disclosing that the members are jointly and severally liable for the obligations of the group.
(2) A copy of the group's plan of assessment.
(3) The amount of specific and aggregate stop loss or excess insurance or reinsurance carried by the group, the amount

and kind of risk retained by the group, and the name and rating of the insurer providing stop loss, excess insurance, or reinsurance. (1997-362, s. 3.)

§ 58-47-135. Assessment plan and indemnity agreement.

(a) Each group shall establish an assessment plan that provides for a reasonable and equitable mechanism for assessing its members. The plan and any amendments shall be approved by the Commissioner. The plan shall include descriptions of the circumstances that initiate an assessment, basis, and allocation to members of the amount being assessed, and collection of the assessment.

(b) The board shall notify the Commissioner of an assessment no fewer than 60 days before an assessment.

(c) The Commissioner shall impose an assessment on members if the board or third-party administrator fails to take action to correct a hazardous financial condition.

(d) Every group shall file an indemnity agreement on a form prescribed by the Commissioner, which jointly and severally binds the members of the group to comply with the provisions of the act and pay obligations imposed by the Act. (1997-362, s. 3.)

§ 58-47-140. Other provisions of this Chapter.

G.S. 58-1-10, 58-2-45, 58-2-50, 58-2-70, 58-2-100, 58-2-105, 58-2-155, 58-2-161, 58-2-180, 58-2-185, 58-2-190, 58-2-200, 58-3-71, 58-3-81, 58-3-100, 58-3-120, 58-3-125, 58-6-25, 58-7-21, 58-7-26, 58-7-30, 58-7-33, and Articles 13, 19, 30, 33, 34, and 63 of this Chapter apply to groups. (1997-362, s. 3.)

Part 2. Third-Party Administrators and Service Companies For Individual And Group Self-insurers.

§ 58-47-150. Definitions.

As used in this Part:

(1) "Books and records" means all files, documents, and databases in a paper form, electronic medium, or both.

(2) "Self-insurer" means a group of employers licensed by the Commissioner under Part 1 of this Article or a single employer licensed by the Commissioner under Article 5 of Chapter 97 of the General Statutes to retain its liability under the Workers' Compensation Act and to pay directly the compensation in the amount and manner and when due as provided for in the Act.

(3) "Service company" means an entity that has contracted with a self-insurer for the purpose of providing any services related to claims adjustment, loss control, or both.

(4) "Third-party administrator" or "TPA" means a person engaged by a self-insurer to execute the policies established by the self-insurer and to provide day-to-day management of the self-insurer. "Third-Party Administrator" and "TPA" does not mean:

a. A self-insurer acting on behalf of its employees or the employees of one or more of its affiliates.
b. An insurer that is licensed under this Chapter or that is acting as an insurer with respect to a policy lawfully issued and delivered by it and under the laws of a state in which the insurer is licensed to write insurance.
c. An agent or broker who is licensed by the Commissioner under Article 33 of this Chapter whose activities are limited exclusively to the sale of insurance.
d. An adjuster licensed by the Commissioner under Article 33 of this Chapter whose activities are limited to adjustment of claims.
e. An individual who is an officer, a member, or an employee of a board.

(5) "Underwriting" means the process of selecting risks and classifying them according to their degrees of insurability so that the appropriate rates may be assigned. The process also includes rejection of those risks that do not qualify. (1997-362, s. 3.)

Editor's Note. — Session Laws 1997-362, s. 10, made this Part effective December 1, 1997.

§ 58-47-155. TPAs and service companies; authority; qualifications.

(a) No person shall act as, offer to act as, or hold himself or herself out as a TPA or a service company with respect to risks located in this State for a self-insurer unless that person complies with this Article.

(b) A TPA or service company shall post with the self-insurer a fidelity bond or other appropriate coverage, issued by an authorized insurer, in a form acceptable to the Commissioner, in an amount commensurate with the risk, and with the governing board of the self-insurer as obligee or beneficiary.

(c) A TPA or service company shall maintain errors and omissions coverage or other appropriate liability insurance in a form acceptable to the Commissioner and in an amount commensurate with the risk. The governing body of the self-insurer shall be obligee or beneficiary of the coverage or insurance.

(d) If the Commissioner determines that a TPA or service company or any other person has not materially complied with this Article or with any rule adopted or order issued under this Article, after notice and opportunity to be heard, the Commissioner may order for each separate violation a civil penalty under G.S. 58-2-70(d).

(e) If the Commissioner finds that because of a material noncompliance that a self-insurer has suffered any loss or damage, the Commissioner may maintain a civil action brought by or on behalf of the self-insurer and its covered members or persons and creditors for recovery of compensatory damages for the benefit of the self-insurer and its covered members or persons and creditors, or for other appropriate relief.

(f) Nothing in this Article affects the Commissioner's right to impose any other penalties provided for in this Chapter or limits or restricts the rights of covered members or persons, claimants, and creditors.

(g) If an order of rehabilitation or liquidation of the self-insurer has been entered under Article 30 of this Chapter, and the receiver appointed under that order determines that the TPA or service company or any other person has not materially complied with this Article or any rule adopted or order issued under this Article, and the self-insurer suffered any loss or damage from the noncompliance, the receiver may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the self-insurer. (1997-362, s. 3.)

§ 58-47-160. Written agreement; composition; restrictions.

(a) No person may act as a TPA or service company without a written agreement between the TPA or service company and the self-insurer. The written agreement shall be retained by the self-insurer and the TPA or service company for the duration of the agreement and for five years thereafter. The agreement shall contain all provisions required by this Article, to the extent those requirements apply to the functions performed by the TPA or service company.

(b) Groups shall file with the Commissioner the written agreement, and any amendments to the agreement, within 30 days after execution. Single employers shall furnish the Commissioner, upon request, the written agreement and any amendments to the agreement. The information required by this section, including any trade secrets, shall be kept confidential; provided that the Commissioner may use that information in any judicial or administrative proceeding instituted against the TPA or service company.

(c) The written agreement shall set forth the duties and powers of the TPA or service company and the self-insurer. The Commissioner shall disapprove any such written agreement that:

(1) Subjects the self-insurer to excessive charges for expenses or commission.

(2) Vests in the TPA or service company any control over the management of the affairs of the self-insurer to the exclusion of the governing board of the self-insurer.

(3) Is entered into with any TPA or service company if the person acting as the TPA or service company, or any of the officers or directors of the TPA or service company, is of known bad character or has been affiliated directly or indirectly through ownership, control, management, reinsurance transactions, or other insurance or business relationships with any person known to have been involved in the improper manipulation of assets, accounts, or reinsurance.

(4) Is determined by the Commissioner to contain provisions that are not fair and reasonable to the self-insurer.

(d) The self-insurer, TPA, or service company may, by written notice, terminate the agreement as provided in the agreement. The self-insurer may suspend the underwriting authority of the TPA during the pendency of any dispute regarding the cause for termination of the agreement. The self-insurer shall fulfill any lawful obligations with respect to policies affected by the agreement, regardless of any dispute between the self-insurer and the TPA or service company.

(e) The contract may not be assigned in whole or part by the TPA or service company without prior approval by the governing board of the self-insurer and the Commissioner. (1997-362, s. 3.)

§ 58-47-165. Books and records.

(a) Every TPA or service company shall maintain and make available to the self-insurer complete books and records of all transactions performed on behalf of the self-insurer. The books and records shall be maintained by the self-insurer, TPA, or service company in accordance with G.S. 58-47-180.

(b) The Commissioner shall have access to books and records maintained by a TPA or service company for the purposes of examination, audit, or inspection. The Commissioner shall keep confidential any trade secrets contained in those books and records, including the identity and addresses of the covered members of a self-insurer, except that the Commissioner may use the information in any judicial or administrative proceeding instituted against the TPA or service company.

(c) The Commissioner may use the TPA or service company as an intermediary in the Commissioner's dealings with the self-insurer if the Commissioner determines that this will result in a more rapid and accurate flow of information from the self-insurer and will aid in the self-insurer's compliance with this Article and the Workers' Compensation Act.

(d) The self-insurer shall own the books and records generated by the TPA or service company pertaining to the self-insurer's business.

(e) The self-insurer shall have access to and rights to duplicate all books and records related to its business.

(f) If the self-insurer and the TPA or service company cancel their agreement, notwithstanding the provisions of subsection (a) of this section, the TPA or service company, shall transfer all books and records to the new TPA, service company, or the self-insurer in a form acceptable to the Commissioner. The new TPA or service company shall acknowledge, in writing, that it is responsible for retaining the books and records of the previous TPA, service company, or the self-insurer as required in subsection (a) of this section. (1997-362, s. 3.)

§ 58-47-170. Payments to TPA or service company.

If a self-insurer uses the services of a TPA, the payment to the TPA of any premiums or charges for insurance by or on behalf of the insured party is considered payment to the self-insurer. The payment of return premiums or claim payments forwarded by the self-insurer to the TPA or service company is not considered payment to the insured party or claimant until the payments are received by the insured party or claimant. This section does not limit any right of the self-insurer against the TPA or service company resulting from the failure of the TPA or service company to make payments to the self-insurer, insured parties, or claimants. (1997-362, s. 3.)

§ 58-47-175. Approval of advertising.

A TPA or service company may use only the advertising pertaining to or affecting the business underwritten by a self-insurer that has been approved in writing by the self-insurer before its use. (1997-362, s. 3.)

§ 58-47-180. Premium collection and payment of claims.

(a) The TPA or service company, at a minimum, shall:

(1) Periodically render an accounting to the self-insurer detailing all transactions performed by the TPA or service company pertaining to the business underwritten, premium or other charges collected, and claims paid by the self-insurer, when applicable.

(2) Deposit all receipts directly into an account maintained in the name of the self-insurer.

(3) Pay claims on drafts or checks of and authorized by the self-insurer.

(4) Not withdraw from the self-insurer's account except for authority limited to pay claims and refund premiums.

(5) Remit return premium, directly from the self-insurer's account, to the person entitled to the return premium.

(b) Any check disbursement authority granted to the TPA or service company may be terminated upon the self-insurer's written notice to the TPA or service company or upon termination of the agreement. The self-insurer may suspend the check disbursement authority during the pendency of any dispute regarding the cause for termination. (1997-362, s. 3.)

§ 58-47-185. Notices; disclosure.

(a) When the services of a TPA are used, the TPA shall provide a written notice approved by the self-insurer to covered members advising them of the identity of, and relationship among, the TPA, the member, and the self-insurer.

(b) When a TPA collects funds, the reason for collection of each item shall be identified to the member and each item shall be shown separately from any premium. Additional charges may not be made for services to the extent the services have been paid for by the self-insurer.

(c) The TPA shall disclose to the self-insurer all charges, fees, and commissions received from all services in connection with the provision of administrative services for the self-insurer, including any fees or commissions paid by self-insurers for obtaining reinsurance.

(d) The TPA or service company shall disclose to the self-insurer the nature of other business in which it is involved. (1997-362, s. 3.)

§ 58-47-190. Compensation.

A TPA or service company shall not enter into any agreement or understanding with a self-insurer that makes the amount of the TPA's or service company's commissions, fees, or charges contingent upon savings affected in the adjustment, settlement, and payment of losses covered by the self-insurer's obligations. This section does not prohibit a TPA or service company from receiving performance-based compensation for providing medical services through a physician-based network or auditing services and does not prevent the compensation of a TPA or service company from being based on premiums or charges collected or the number of claims paid or processed. (1997-362, s. 3.)

§ 58-47-195. Examinations.

TPAs and service companies may be examined under G.S. 58-2-131, 58-2-132, and 58-2-133. (1997-362, s. 3.)

§ 58-47-200. Unfair trade practices.

TPAs and service companies are subject to Article 63 of this Chapter. (1997-362, s. 3.)

§ 58-47-205. Other requirements.

(a) A TPA or service company, or any owner, officer, employee, or agent of a TPA or service company, or any other person affiliated with or related to the TPA or service company shall not serve as a trustee of a self-insurer.

(b) Each TPA or service company shall make available for inspection by the Commissioner copies of all contracts with persons using the services of the TPA. (1997-362, s. 3.)

ARTICLE 48.

Postassessment Insurance Guaranty Association.

§ 58-48-1. Short title.

CASE NOTES

Cited in North Carolina Ins. Guar. Ass'n v. State Farm Mut. Auto. Ins. Co., 115 N.C. App. 666, 446 S.E.2d 364 (1994); Fieldcrest Cannon, Inc. v. Fireman's Fund Ins. Co., 124 N.C. App. 232, 477 S.E.2d 59 (1996).

§ 58-48-5. Purpose of Article.

CASE NOTES

Quoted in Hales v. North Carolina Ins. Guar. Ass'n, 337 N.C. 329, 445 S.E.2d 590 (1994); North Carolina Ins. Guar. Ass'n v. Century Indem. Co., 115 N.C. App. 175, 444 S.E.2d 464, cert. denied, 337 N.C. 696, 448 S.E.2d 532 (1994).

§ 58-48-20. Definitions.

CASE NOTES

Subrogation and Contribution. — Because subrogation and contribution are contractual or tort based forms of remedies and equitable subrogation is a judicially imposed remedy grounded in equity, the phrase "or otherwise" as used in subsection (4) does not encompass the purely equitable remedy. North Carolina Ins. Guar. Ass'n v. Century Indem. Co., 115 N.C. App. 175, 444 S.E.2d 464, cert. denied, 337 N.C. 696, 448 S.E.2d 532 (1994).

Quoted in Hales v. North Carolina Ins. Guar. Ass'n, 337 N.C. 329, 445 S.E.2d 590 (1994).

§ 58-48-35. Powers and duties of the Association.

CASE NOTES

The General Assembly did not intend for the term "subrogation" to encompass equitable subrogation, particularly in a context in which plaintiff failed to fulfill its statutory obligation under subdivision (a)(1), based upon its misreading of the insurance contract. North Carolina Ins. Guar. Ass'n v. Century Indem. Co., 115 N.C. App. 175, 444 S.E.2d 464, cert. denied, 337 N.C. 696, 448 S.E.2d 532 (1994).

Police Power of Commissioner — Where, in order to determine which claims to pursue and which to abandon, it was necessary for the Commissioner and the Association to review plaintiff's claim files, the Commissioner seeking custody of the files was well within the usual scope of police power activity conducted to protect the general welfare. Eastern Appraisal Servs., Inc. v. State, 118 N.C. App. 692, 457 S.E.2d 312, appeal dismissed, cert. denied, 341 N.C. 648, 462 S.E.2d 509 (1995).

Defendant's Umbrella Coverage Did Not "Drop Down" to Primary Coverage. — Where there was no ambiguity as to the term "amount recoverable" or as to the scope of coverage and the primary insurer's insolvency did not constitute an occurrence as that term was defined in the policy, defendant's umbrella coverage did not "drop down" to become primary coverage. North Carolina Ins. Guar. Ass'n v. Century Indem. Co., 115 N.C. App. 175, 444 S.E.2d 464, cert. denied, 337 N.C. 696, 448 S.E.2d 532 (1994).

Defendant insurer was entitled to be paid by the association an amount up to the statutory cap, as stated in subdivision (a)(1). North Carolina Ins. Guar. Ass'n v. Century Indem. Co., 115 N.C. App. 175, 444 S.E.2d 464, cert. denied, 337 N.C. 696, 448 S.E.2d 532 (1994).

Cited in Hales v. North Carolina Ins. Guar. Ass'n, 337 N.C. 329, 445 S.E.2d 590 (1994).

§ 58-48-60. Prevention of insolvencies.

(a) Repealed by Session Laws 1989, c. 206, s. 7.

(b) To aid in the detection and prevention of insurer insolvencies, the board of directors may, upon majority vote, request that the Commissioner order an examination of any member insurer which the board in good faith believes may be in a financial condition hazardous to the policyholders or the public. Within 30 days of the receipt of such request, the Commissioner shall begin such examination. The examination may be conducted as an NAIC examination or may be conducted by such persons as the Commissioner designates. The examination report shall be treated as are other examination reports. In no event shall such examination report be released to the board of directors prior to its release to the public, but this shall not preclude the Commissioner from complying with subsection (c) below. The Commissioner shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the Commissioner but it shall not be open to public inspection prior to the release of the examination report to the public.

(c) It shall be the duty of the Commissioner to report to the board of directors when he has reasonable cause to believe that any member insurer examined or being examined at the request of the board of directors may be insolvent or in a financial condition hazardous to the policyholders or the public.

(d) The board of directors may, upon majority vote, make reports and recommendations to the Commissioner upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer. Such reports and recommendations shall not be considered public documents.

(e) The board of directors may, upon majority vote, make recommendations to the Commissioner for the detection and prevention of insurer insolvencies.

(f) The board of directors may, at the conclusion of any domestic insurer insolvency in which the Association was obligated to pay covered claims, prepare a report on the history and causes of such insolvency, based on the information available to the Association, and submit such report to the Commissioner. (1971, c. 670, s. 1; 1989, c. 206, s. 7; 1991, c. 720, s. 27; 1995, c. 360, s. 2(j).)

ARTICLE 49.

Determination of Jurisdiction Over Providers of Health Care Benefits; Regulation of Multiple Employer Welfare Arrangements.

§ 58-49-5. Authority and jurisdiction of Commissioner.

Notwithstanding any other provision of law, and except as provided in this Article, any person that provides coverage in this State for medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital, or optometric expenses, whether the coverage is by direct payment, reimbursement, or otherwise, shall be presumed to be subject to the jurisdiction of the Commissioner, unless the person shows that while providing the services it is subject to the exclusive jurisdiction of another agency or subdivision of this State or of the federal government. (1985, c. 304, s. 1; 1993 (Reg. Sess., 1994), c. 569, s. 2; 1995, c. 193, s. 40.)

Editor's Note. — Session Laws 1995, c. 193, s. 67 contains a severability clause.

ARTICLE 50.

General Regulations.

§ 58-50-25. Nurses' services.

(a) No agency, institution or physician providing a service for which payment or reimbursement is required to be made under a policy governed by Articles 1 through 64 of this Chapter shall be denied such payment or reimbursement on account of the fact that such services were rendered through a registered nurse acting under authority of rules and regulations adopted by the North Carolina Medical Board and the Board of Nursing pursuant to G.S. 90-6 and 90-171.23.

(b) A licensed registered nurse who has successfully completed a program established under G.S. 90-171.38(b) may receive direct payment for conducting medical examinations or medical procedures for the purpose of collecting evidence from victims of offenses described in that subsection if the payment would have otherwise been permitted. (1973, c. 437; 1991, c. 720, s. 37; 1993, c. 347, s. 1; 1995, c. 94, s. 2; 1997-197, s. 1; 1997-375, s. 3.)

Editor's Note. — Session Laws 1997-197, s. 1, amended Session Laws 1993, c. 347, s. 5, to repeal the expiration date of October 1, 1998 for that act.

Effect of Amendments. — The 1995 amendment substituted "North Carolina Medical Board" for "Board of Medical Examiners".

The 1997 amendment, effective August 6, 1997, added the subsection designations, and added the second sentence of subsection (b).

§ 58-50-30. (Effective until July 1, 1999) Discrimination forbidden; right to choose services of optometrist, podiatrist, certified clinical social worker, dentist, chiropractor, psychologist, pharmacist, certified fee-based practicing pastoral counselor, or advanced practice registered nurse.

(a) **(Effective until October 1, 1998)** Discrimination between individuals of the same class in the amount of premiums or rates charged for any policy of insurance covered by Articles 50 through 55 of this Chapter, or in the benefits payable thereon, or in any of the terms or conditions of such policy, or in any other manner whatsoever, is prohibited.

Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for payment of or reimbursement for any service rendered in connection with a condition or complaint which is within the scope of practice of a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, a duly licensed pharmacist, a duly certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, the insured or other persons entitled to benefits under such policy shall be entitled to payment of or reimbursement for such services, whether such services be performed by a duly licensed physician, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, a duly licensed pharmacist, a duly certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, notwithstanding any provision contained in such policy. Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for certification of disability which is within the scope of practice of a duly licensed physician, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, a duly certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, the insured or other persons entitled to benefits under such policy shall be entitled to payment of or reimbursement for such disability whether such disability be certified by a duly licensed physician, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, a duly certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, notwithstanding any provisions contained in such policy. The policyholder, insured, or beneficiary shall have the right to choose the provider of such services notwithstanding any provision to the contrary in any other statute.

Whenever any policy of insurance provides coverage for medically necessary treatment, the insurer shall not impose any limitation on treatment or levels of coverage if performed by a duly licensed chiropractor acting within the scope of his practice as defined in G.S. 90-151 unless a comparable limitation is imposed on such medically necessary treatment if performed or authorized by any other duly licensed physician.

(a) **(Effective October 1, 1998)** Discrimination between individuals of the same class in the amount of premiums or rates charged for any policy of insurance covered by Articles 50 through 55 of this Chapter, or in the benefits payable thereon, or in any of the terms or conditions of such policy, or in any other manner whatsoever, is prohibited.

Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for payment of or reimbursement for any service rendered in connection with a condition or complaint that is within the scope of practice of a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, a duly licensed pharmacist, a duly certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the services, whether the services be performed by a duly licensed physician, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, a duly licensed pharmacist, a duly certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, notwithstanding any provision contained in the policy. Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for certification of disability that is within the scope of practice of a duly licensed physician, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, a duly certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, the insured or other persons entitled to benefits under such policy shall be entitled to payment of or reimbursement for the disability whether such disability be certified by a duly licensed physician, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, a duly certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, notwithstanding any provisions contained in such policy. The policyholder, insured, or beneficiary shall have the right to choose the provider of the services notwithstanding any provision to the contrary in any other statute.

Whenever any policy of insurance provides coverage for medically necessary treatment, the insurer shall not impose any limitation on treatment or levels of coverage if performed by a duly licensed chiropractor acting within the scope of his practice as defined in G.S. 90-151 unless a comparable limitation is imposed on such medically necessary treatment if performed or authorized by any other duly licensed physician.

(b) For the purposes of this section, a "duly licensed psychologist" shall be defined only to include a psychologist who is duly licensed in the State of North Carolina and has a doctorate degree in psychology and at least two years clinical experience in a recognized health setting, or has met the standards of the National Register of Health Service Providers in Psychology. After January 1, 1995, a duly licensed psychologist shall be defined as a licensed psychologist who holds permanent licensure and certification as a health services provider psychologist issued by the North Carolina Psychology Board.

(c) For the purposes of this section, a "duly certified clinical social worker" is a "certified clinical social worker" as defined in G.S. 90B-3(2) and certified by the North Carolina Certification Board for Social Work pursuant to Chapter 90B of the General Statutes.

(c1) For purposes of this section, a "duly certified fee-based practicing pastoral counselor" shall be defined only to include fee-based practicing pastoral counselors certified by the North Carolina State Board of Examiners of Fee-Based Practicing Pastoral Counselors pursuant to Article 26 of Chapter 90 of the General Statutes.

(d) Payment or reimbursement is required by this section for a service performed by an advanced practice registered nurse only when:

(1) The service performed is within the nurse's lawful scope of practice;
(2) The policy currently provides benefits for identical services performed by other licensed health care providers;
(3) The service is not performed while the nurse is a regular employee in an office of a licensed physician;

§ 58-50-30 is set out twice. See notes.

(4) The service is not performed while the registered nurse is employed by a nursing facility (including a hospital, skilled nursing facility, intermediate care facility, or home care agency); and

(5) Nothing in this section is intended to authorize payment to more than one provider for the same service.

No lack of signature, referral, or employment by any other health care provider may be asserted to deny benefits under this provision.

For purposes of this section, an "advanced practice registered nurse" means only a registered nurse who is duly licensed or certified as a nurse practitioner, clinical specialist in psychiatric and mental health nursing, or nurse midwife.

(e) Payment or reimbursement is required by this section for a service performed by a duly licensed pharmacist only when:

(1) The service performed is within the lawful scope of practice of the pharmacist;

(2) The service performed is not initial counseling services required under State or federal law or regulation of the North Carolina Board of Pharmacy;

(3) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and

(4) The service is identified as a separate service that is performed by other licensed health care providers and is reimbursed by identical payment methods.

Nothing in this subsection authorizes payment to more than one provider for the same service. (1913, c. 91, s. 11; C.S., s. 6488; 1965, c. 396, s. 2; c. 1169, s. 2; 1967, c. 690, s. 2; 1969, c. 679; 1973, c. 610; 1977, c. 601, ss. 2, 3½; 1991, c. 720, s. 29; 1993, c. 347, s. 2; c. 375, s. 3; c. 464, s. 2; c. 554, s. 1; 1995, c. 223, s. 1; c. 406, s. 3; 1997-197, ss. 1, 2.)

Section Set Out Twice. — The section set out above expires July 1, 1999. For the section as effective after July 1, 1999, see the following section, also numbered § 58-50-30.

Subsection (a) Set Out Twice. — The first version of subsection (a) set out above is effective until October 1, 1998. The second version of subsection (a) set out above is effective October 1, 1998.

Editor's Note. —

Session Laws 1993, c. 464, s. 8, provided that s. 2 of c. 464, which inserted "certified clinical social worker" in the catchline to this section; added subsection designations for subsection (a) and subsection (b) (redesignated as subsection (d) at the direction of the Revisor of Statutes); in present subsection (a) inserted each instance of "a duly certified clinical social worker"; and added present subsection (c), would expire June 30, 1999. The expiration date was deleted by Session Laws 1997-197, s. 2.

Session Laws 1993, c. 347, s. 5 provided that the amendment by c. 347, s. 2 applied to all plans and policies with an inception, renewal, or anniversary date on or after October 1, 1993, and expired October 1, 1998. The expiration date was deleted by Session Laws 1997-197, s. 1.

Session Laws 1995, c. 193, s. 67, contains a severability clause.

Session Laws 1995, c. 223, s. 1, which amended this section, was effective July 1, 1995 and applicable to claims for payment or reimbursement for services rendered on or after that date.

Session Laws 1995, c. 406, s. 3, effective July 15, 1995 and expiring July 1, 1999, and applicable to treatment or services rendered on or after that date, added "certified fee-based practicing pastoral counselor" in the catchline of this section; added "a duly certified fee-based practicing pastoral counselor" throughout the second paragraph of subsection (a); and added subsection (c1).

§ 58-50-30. (Effective July 1, 1999) Discrimination forbidden; right to choose services of optometrist, podiatrist, certified clinical social worker, dentist, chiropractor, psychologist, pharmacist, or advanced practice registered nurse.

(a) **(See editor's note)** Discrimination between individuals of the same class in the amount of premiums or rates charged for any policy of insurance covered by Articles 50 through 55 of this Chapter, or in the benefits payable thereon, or in any of the terms or conditions of the policy, or in any other manner whatsoever, is prohibited.

Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for payment of or reimbursement for any service rendered in connection with a condition or complaint that is within the scope of practice of a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, a duly licensed pharmacist, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the services, whether the services be performed by a duly licensed physician, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, a duly licensed pharmacist, or an advanced practice registered nurse, notwithstanding any provision contained in the policy. Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for certification of disability that is within the scope of practice of a duly licensed physician, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the disability whether such disability be certified by a duly licensed physician, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, or an advanced practice registered nurse, notwithstanding any provisions contained in the policy. The policyholder, insured, or beneficiary shall have the right to choose the provider of the services notwithstanding any provision to the contrary in any other statute.

Whenever any policy of insurance provides coverage for medically necessary treatment, the insurer shall not impose any limitation on treatment or levels of coverage if performed by a duly licensed chiropractor acting within the scope of the chiropractor's practice as defined in G.S. 90-151 unless a comparable limitation is imposed on the medically necessary treatment if performed or authorized by any other duly licensed physician.

(b) For the purposes of this section, a "duly licensed psychologist" shall be defined only to include a psychologist who is duly licensed in the State of North Carolina and has a doctorate degree in psychology and at least two years clinical experience in a recognized health

§ 58-50-30 is set out twice. See notes.

setting, or has met the standards of the National Register of Health Service Providers in Psychology. After January 1, 1995, a duly licensed psychologist shall be defined as a licensed psychologist who holds permanent licensure and certification as a health services provider psychologist issued by the North Carolina Psychology Board.

(c) For the purposes of this section, a "duly certified clinical social worker" is a "certified clinical social worker" as defined in G.S. 90B-3(2) and certified by the North Carolina Certification Board for Social Work pursuant to Chapter 90B of the General Statutes.

(c1) Expired.

(d) Expired.

(e) Payment or reimbursement is required by this section for a service performed by a duly licensed pharmacist only when:

(1) The service performed is within the lawful scope of practice of the pharmacist;

(2) The service performed is not initial counseling services required under State or federal law or regulation of the North Carolina Board of Pharmacy;

(3) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and

(4) The service is identified as a separate service that is performed by other licensed health care providers and is reimbursed by identical payment methods.

Nothing in this subsection authorizes payment to more than one provider for the same service. (1913, c. 91, s. 11; C.S., s. 6488; 1965, c. 396, s. 2; c. 1169, s. 2; 1967, c. 690, s. 2; 1969, c. 679; 1973, c. 610; 1977, c. 601, ss. 2, 3½; 1991, c. 720, s. 29; 1993, c. 347, s. 2; c. 375, s. 3; c. 464, s. 2; c. 554, s. 1; 1995, c. 193, s. 41; c. 223, s. 1; c. 406, s. 3.)

Section Set Out Twice. — The section set out above is effective July 1, 1999. For the section as effective until July 1, 1999, see the preceding section, also numbered § 58-50-30.

Editor's Note. — Subsection (a), as set out above, becomes effective after the expiration of the amendments by Session Laws 1995, c. 406, s. 3, on July 1, 1999.

Session Laws 1993, c. 464, s. 8, provided that s. 2 of c. 464, which amended this section, would expire June 30, 1999. The expiration date was deleted by Session Laws 1997-197, s. 2.

Session Laws 1995, c. 406, s. 6, provides that the amendments to this section by Session Laws 1995, c. 406, s. 3, expire July 1, 1999.

Session Laws 1995, c. 193, s. 67, contains a severability clause.

Effect of Amendments. — Session Laws 1995, c. 223, s. 1, effective July 1, 1995, and applicable to claims for payment or reimbursement for services rendered on or after that date, inserted "pharmacist" in the catchline and made a related change; inserted "a duly licensed pharmacist" twice in the first sentence of the second paragraph of subsection (a); and added subsection (e).

Session Laws 1995, c. 406, s. 3, effective July 15, 1995, and applicable to treatment or services rendered on or after that date, expire July 1, 1999.

Session Laws 1995, c. 193, s. 41, amends subsection (a) of this section effective October 1, 1998, by substituting "the chiropractor's" for "his" in the last paragraph and making stylistic changes throughout the subsection.

§ 58-50-50: Repealed by Session Laws, 1997-519, s. 3.17, effective January 1, 1998.

Cross References. — For present provisions regarding preferred providers, see § 58-55-56.

Editor's Note. — Session Laws 1997-519, s. 3.19, effective January 1, 1998, provides: "Except as modified by G.S. 58-50-56(i), as enacted in this Part, any administrative rules that were adopted by the Commissioner under the authority of G.S. 58-50-50 or G.S. 58-50-55 and that were effective before January 1, 1998, are not affected by the repeals in Section 3.17 of this act." Section 3.17 of the act provided for the repeal of §§ 58-50-50 and 58-50-55.

§ 58-50-55: Repealed by Session Laws 1997-519, s. 3.17, effective January 1, 1998.

Editor's Note. — Session Laws 1997-519, s. 3.19, effective January 1, 1998, provides: "Except as modified by G.S. 58-50-56(i), as enacted in this Part, any administrative rules that were adopted by the Commissioner under the authority of G.S. 58-50-50 or G.S. 58-50-55 and that were effective before January 1, 1998, are not affected by the repeals in Section 3.17 of this act." Section 3.17 of the act provided for the repeal of §§ 58-50-50 and 58-50-55.

§ 58-50-56. Insurers, preferred provider organizations, and preferred provider benefit plans.

(a) Definitions. — As used in this section:

(1) "Insurer" means an insurer or service corporation subject to this Chapter.

(2) "Preferred provider" means a health care provider who has agreed to accept special reimbursement or other terms for health care services from an insurer for health care services on a fee-for-service basis. A "preferred provider" is not a health care provider participating in any prepaid health service or capitation arrangement implemented or administered by the Department of Health and Human Services or its representatives.

(3) "Preferred provider benefit plan" means a health benefit plan offered by an insurer in which both of the following features are present:

a. Utilization review or quality management programs are used to manage the provision of covered health care services; and

b. Enrollees are given incentives through benefit differentials to limit the receipt of covered health care services to those furnished by participating providers, and health care services are provided by preferred providers under a contract pursuant to this section.

(4) "Preferred provider organization" or "PPO" means an insurer holding contracts with preferred providers to be used by or offered to insurers offering preferred provider benefit plans.

(b) Insurers may enter into preferred provider contracts or enter into other cost containment arrangements approved by the Commissioner to reduce the costs of providing health care services. These contracts or arrangements may be entered into with licensed health care providers of all kinds without regard to specialty of services or limitation to a specific type of practice.

(c) At the initial offering of a preferred provider plan to the public, health care providers may submit proposals for participation in accordance with the terms of the preferred provider plan within 30 days after that offering. After that time period, any health care provider may submit a proposal, and the insurer offering the preferred provider benefit plan shall consider all pending applications for participation and give reasons for any rejections or failure to act on an application on at least an annual basis. Any health care provider seeking to participate in the preferred provider benefit plan, whether upon the initial offering or subsequently, may be permitted to do so in the discretion of the insurer offering the preferred provider benefit plan. The second and third paragraphs of G.S. 58-50-30(a) apply to preferred provider benefit plans.

(d) Any provision of a contract between an insurer offering a preferred provider benefit plan and a health care provider that restricts the provider's right to enter into preferred provider contracts with other persons is prohibited, is void ab initio, and is not enforceable. The existence of that restriction does not invalidate any other provision of the contract.

(e) Except where specifically prohibited either by this section or by rules adopted by the Commissioner, the contractual terms and conditions for special reimbursements shall be those that the parties find mutually agreeable.

(f) Every insurer offering a preferred provider benefit plan and contracting with a PPO shall require by contract that the PPO shall provide all of the preferred providers with whom it holds contracts information about the insurer and the insurer's preferred provider benefit plans. This information shall include for each insurer and preferred provider benefit plan the benefit designs and incentives that are used to encourage insureds to use preferred providers.

(g) The Commissioner may adopt rules applicable to insurers offering preferred provider benefit plans under this section. These rules shall provide for:

(1) Accessibility of preferred provider services to individuals within the insured group.
(2) The adequacy of the number and locations of health care providers.
(3) The availability of services at reasonable times.
(4) Financial solvency.

(h) Each insurer offering a preferred provider benefit plan shall provide the Commissioner with summary data about the financial reimbursements offered to health care providers. All such insurers shall disclose annually the following information:

(1) The name by which the preferred provider benefit plan is known and its business address.
(2) The name, address, and nature of any PPO or other separate organization that administers the preferred provider benefit plan for the insurer.
(3) The terms of the agreements entered into by the insurer with preferred providers.
(4) Any other information necessary to determine compliance with this section, rules adopted under this section, or other requirements applicable to preferred provider benefit plans.

(i) A person enrolled in a preferred provider benefit plan may obtain covered health care services from a provider who does not participate in the plan. In accordance with rules adopted by the Commissioner and subject to G.S. 58-3-200(d), the preferred provider benefit plan may limit coverage for health care services obtained from a nonparticipating provider. The Commissioner shall adopt rules on product limitations, including payment differentials for services rendered by nonparticipating providers. These rules shall be similar in substance to rules governing HMO point-of-service products.

(j) A list of the current participating providers in the geographic area in which a substantial portion of health care services will be available shall be provided to insureds and contracting parties.

(k) Publications or advertisements of preferred provider benefit plans or organizations shall not refer to the quality or efficiency of the services of nonparticipating providers. (1997-443, s. 11A.122; 1997-519, s. 3.1.)

Editor's Note. — Session Laws 1997-443, s. 1.1, provides "This act shall be known as "The Current Operations and Capital Improvements Appropriations Act of 1997.'"

Session Laws 1997-443, s. 35.4, is a severability clause.

Session Laws 1997-519, s. 5, made this section effective January 1, 1998.

Session Laws 1997-519, s. 3.19, effective January 1, 1998, provides: "Except as modified by G.S. 58-50-56(i), as enacted in this Part, any administrative rules that were adopted by the Commissioner under the authority of G.S. 58-50-50 or G.S. 58-50-55 and that were effective before January 1, 1998, are not affected by the repeals in Section 3.17 of this act." Section 3.17 of the act provided for the repeal of §§ 58-50-50 and 58-50-55.

Effect of Amendments. — Session Laws 1997-443, s. 11A.122, effective August 28, 1997, substituted "Health and Human Services" for "Human Resources" in subdivision (a)(2).

§§ 58-50-57 through 58-50-59: Reserved for future codification purposes.

§ 58-50-60: Repealed by Session Laws 1997-519, s. 4.4, effective January 1, 1998.

§ 58-50-61. Utilization review.

(a) Definitions. — As used in this section and in G.S. 58-50-62, the term:

(1) "Clinical peer" means a health care professional who holds an unrestricted license in a state of the United States, in the same or similar specialty, and routinely provides the health care services subject to utilization review.

(2) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by an insurer to determine medically necessary services and supplies.

(3) "Covered person" means a policyholder, subscriber, enrollee, or other individual covered by a health benefit plan. "Covered person" includes another person, other than the covered person's provider, who is authorized to act on behalf of a covered person.

(4) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity

including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

a. Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
b. Serious impairment to bodily functions.
c. Serious dysfunction of any bodily organ or part.

(5) "Emergency services" means health care items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department.

(6) "Grievance" means a written complaint submitted by a covered person about any of the following:

a. An insurer's decisions, policies, or actions related to availability, delivery, or quality of health care services.
b. Claims payment or handling; or reimbursement for services.
c. The contractual relationship between a covered person and an insurer.
d. The outcome of an appeal of a noncertification under this section.

(7) "Health benefit plan" means any of the following if offered by an insurer: an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; or a plan provided by a multiple employer welfare arrangement. "Health benefit plan" does not mean any plan implemented or administered through the Department of Health and Human Services or its representatives. "Health benefit plan" also does not mean any of the following kinds of insurance:

a. Accident.
b. Credit.
c. Disability income.
d. Long-term or nursing home care.
e. Medicare supplement.
f. Specified disease.
g. Dental or vision.
h. Coverage issued as a supplement to liability insurance.
i. Workers' compensation.
j. Medical payments under automobile or homeowners.
k. Hospital income or indemnity.
l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

(8) "Health care provider" means any person who is licensed, registered, or certified under Chapter 90 of the General Statutes; a health care facility as defined in G.S. 131E-176(9b); or a pharmacy.

(9) "Health care services" means services provided for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(10) "Insurer" means an entity that writes a health benefit plan and that is an insurance company subject to this Chapter, a service corporation under Article 65 of this Chapter, a health maintenance organization under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 49 of this Chapter.

(11) "Managed care plan" means a health benefit plan in which an insurer either (i) requires a covered person to use or (ii) creates incentives, including financial incentives, for a covered person to use providers that are under contract with or managed, owned, or employed by the insurer.

(12) "Medically necessary services or supplies" means those covered services or supplies that are:

a. Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease.

b. Not for experimental, investigational, or cosmetic purposes.

c. Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.

d. Within generally accepted standards of medical care in the community.

e. Not solely for the convenience of the insured, the insured's family, or the provider.

For medically necessary services, nothing in this subdivision precludes an insurer from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

(13) "Noncertification" means a determination by an insurer or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service is therefore denied, reduced, or terminated. A "noncertification" is not a decision rendered solely on the basis that the health benefit plan does not provide benefits for the health care service in question, if the exclusion of the specific service requested is clearly stated in the certificate of coverage.

(14) "Participating provider" means a provider who, under a contract with an insurer or with an insurer's contractor or subcontractor, has agreed to provide health care services to covered persons in return for direct or indirect payment from the insurer, other than coinsurance, copayments, or deductibles.

(15) "Provider" means a health care provider.

(16) "Stabilize" means to provide medical care that is appropriate to prevent a material deterioration of the person's condition, within reasonable medical probability, in accordance with the HCFA (Health Care Financing Administration) interpretative guidelines, policies, and regulations pertaining to responsibilities of hospitals in emergency cases (as provided under the Emergency Medical Treatment and Labor Act, section 1867 of the Social Security Act,

42 U.S.C.S. § 1395dd), including medically necessary services and supplies to maintain stabilization until the person is transferred.

(17) "Utilization review" means a set of formal techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers, or facilities. These techniques may include:

a. Ambulatory review. — Utilization review of services performed or provided in an outpatient setting.

b. Case management. — A coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.

c. Certification. — A determination by an insurer or its designated URO that an admission, availability of care, continued stay, or other service has been reviewed and, based on the information provided, satisfies the insurer's requirements for medically necessary services and supplies, appropriateness, health care setting, level of care, and effectiveness.

d. Concurrent review. — Utilization review conducted during a patient's hospital stay or course of treatment.

e. Discharge planning. — The formal process for determining, before discharge from a provider facility, the coordination and management of the care that a patient receives after discharge from a provider facility.

f. Prospective review. — Utilization review conducted before an admission or a course of treatment including any required preauthorization or precertification.

g. Retrospective review. — Utilization review of medically necessary services and supplies that is conducted after services have been provided to a patient, but not the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

h. Second opinion. — An opportunity or requirement to obtain a clinical evaluation by a provider other than the provider originally making a recommendation for a proposed service to assess the clinical necessity and appropriateness of the proposed service.

(18) "Utilization review organization" or "URO" means an entity that conducts utilization review under a managed care plan, but does not mean an insurer performing utilization review for its own health benefit plan.

(b) Insurer Oversight. — Every insurer shall monitor all utilization review carried out by or on behalf of the insurer and ensure compliance with this section. An insurer shall ensure that appropriate personnel have operational responsibility for the conduct of the insurer's utilization review program. If an insurer contracts to have a URO perform its utilization review, the insurer shall monitor the URO to ensure compliance with this section, which shall include:

(1) A written description of the URO's activities and responsibilities, including reporting requirements.

(2) Evidence of formal approval of the utilization review organization program by the insurer.

(3) A process by which the insurer evaluates the performance of the URO.

(c) Scope and Content of Program. — Every insurer shall prepare and maintain a utilization review program document that describes all delegated and nondelegated review functions for covered services including:

(1) Procedures to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health services.
(2) Data sources and clinical review criteria used in decision making.
(3) The process for conducting appeals of noncertifications.
(4) Mechanisms to ensure consistent application of review criteria and compatible decisions.
(5) Data collection processes and analytical methods used in assessing utilization of health care services.
(6) Provisions for assuring confidentiality of clinical and patient information in accordance with State and federal law.
(7) The organizational structure (e.g., utilization review committee, quality assurance, or other committee) that periodically assesses utilization review activities and reports to the insurer's governing body.
(8) The staff position functionally responsible for day-to-day program management.
(9) The methods of collection and assessment of data about underutilization and overutilization of health care services and how the assessment is used to evaluate and improve procedures and criteria for utilization review.

(d) Program Operations. — In every utilization review program, an insurer or URO shall use documented clinical review criteria that are based on sound clinical evidence and that are periodically evaluated to assure ongoing efficacy. An insurer may develop its own clinical review criteria or purchase or license clinical review criteria. Qualified health care professionals shall administer the utilization review program and oversee review decisions under the direction of a medical doctor. A medical doctor shall evaluate the clinical appropriateness of noncertifications. Compensation to persons involved in utilization review shall not contain any direct or indirect incentives for them to make any particular review decisions. Compensation to utilization reviewers shall not be directly or indirectly based on the number or type of noncertifications they render. In issuing a utilization review decision, an insurer shall: obtain all information required to make the decision, including pertinent clinical information; employ a process to ensure that utilization reviewers apply clinical review criteria consistently; and issue the decision in a timely manner pursuant to this section.

(e) Insurer Responsibilities. — Every insurer shall:

(1) Routinely assess the effectiveness and efficiency of its utilization review program.
(2) Coordinate the utilization review program with its other medical management activity, including quality assurance, credentialing, provider contracting, data reporting, grievance procedures, processes for assessing satisfaction of covered persons, and risk management.
(3) Provide covered persons and their providers with access to its review staff by a toll-free or collect call telephone number whenever any provider is required to be available

to provide services which may require prior certification to any plan enrollee. Every insurer shall establish standards for telephone accessibility and monitor telephone service as indicated by average speed of answer and call abandonment rate, on at least a month-by-month basis, to ensure that telephone service is adequate, and take corrective action when necessary.

(4) Limit its requests for information to only that information that is necessary to certify the admission, procedure or treatment, length of stay, and frequency and duration of health care services.

(5) Have written procedures for making utilization review decisions and for notifying covered persons of those decisions.

(6) Have written procedures to address the failure or inability of a provider or covered person to provide all necessary information for review. If a provider or covered person fails to release necessary information in a timely manner, the insurer may deny certification.

(f) Prospective and Concurrent Reviews. — As used in this subsection, "necessary information" includes the results of any patient examination, clinical evaluation, or second opinion that may be required. Prospective and concurrent determinations shall be communicated to the covered person's provider within three business days after the insurer obtains all necessary information about the admission, procedure, or health care service. If an insurer certifies a health care service, the insurer shall notify the covered person's provider. For a noncertification, the insurer shall notify the covered person's provider and send written or electronic confirmation of the noncertification to the covered person. In concurrent reviews, the insurer shall remain liable for health care services until the covered person has been notified of the noncertification.

(g) Retrospective Reviews. — As used in this subsection, "necessary information" includes the results of any patient examination, clinical evaluation, or second opinion that may be required. For retrospective review determinations, an insurer shall make the determination within 30 days after receiving all necessary information. For a certification, the insurer may give written notification to the covered person's provider. For a noncertification, the insurer shall give written notification to the covered person and the covered person's provider within five business days after making the noncertification.

(h) Notice of Noncertification. — A written notification of a noncertification shall include all reasons for the noncertification, including the clinical rationale, the instructions for initiating a voluntary appeal or reconsideration of the noncertification, and the instructions for requesting a written statement of the clinical review criteria used to make the noncertification. An insurer shall provide the clinical review criteria used to make the noncertification to any person who received the notification of the noncertification and who follows the procedures for a request.

(i) Requests for Reconsideration. — An insurer may establish procedures for informal reconsideration of noncertifications. The reconsideration shall be conducted between the covered person's provider and a medical doctor designated by the insurer. An insurer shall not require a covered person to participate in an informal reconsideration before the covered person may appeal a noncertification under subsection (j) of this section.

(j) Appeals of Noncertifications. — Every insurer shall have written procedures for appeals of noncertifications by covered persons or their providers acting on their behalves, including expedited review to address a situation where the time frames for the standard review procedures set forth in this section would reasonably appear to seriously jeopardize the life or health of a covered person or jeopardize the covered person's ability to regain maximum function. Each appeal shall be evaluated by a medical doctor who was not involved in the noncertification.

(k) Nonexpedited Appeals. — Within three business days after receiving a request for a standard, nonexpedited appeal, the insurer shall provide the covered person with the name, address, and telephone number of the coordinator and information on how to submit written material. For standard, nonexpedited appeals, the insurer shall give written notification of the decision to the covered person and the covered person's provider within 30 days after the insurer receives the request for an appeal. The written decision shall contain:

(1) The professional qualifications and licensure of the person or persons reviewing the appeal.

(2) A statement of the reviewers' understanding of the reason for the covered person's appeal.

(3) The reviewers' decision in clear terms and the medical rationale in sufficient detail for the covered person to respond further to the insurer's position.

(4) A reference to the evidence or documentation that is the basis for the decision, including the clinical review criteria used to make the determination, and instructions for requesting the clinical review criteria.

(5) A statement advising the covered person of the covered person's right to request a second-level grievance review and a description of the procedure for submitting a second-level grievance under G.S. 58-50-62.

(*l*) Expedited Appeals. — An expedited appeal of a noncertification may be requested by a covered person or his or her provider acting on the covered person's behalf only when a nonexpedited appeal would reasonably appear to seriously jeopardize the life or health of a covered person or jeopardize the covered person's ability to regain maximum function. The insurer may require documentation of the medical justification for the expedited appeal. The insurer shall, in consultation with a medical doctor, provide expedited review, and the insurer shall communicate its decision in writing to the covered person and his or her provider as soon as possible, but not later than four days after receiving the information justifying expedited review. The written decision shall contain the provisions specified in subsection (k) of this section. If the expedited review is a concurrent review determination, the insurer shall remain liable for the coverage of health care services until the covered person has been notified of the determination. An insurer is not required to provide an expedited review for retrospective noncertifications.

(m) Disclosure Requirements. — In the certificate of coverage and member handbook provided to covered persons, an insurer shall include a clear and comprehensive description of its utilization review procedures, including the procedures for appealing noncertifications and a statement of the rights and responsibilities of covered persons, including the voluntary nature of the appeal process, with respect to those procedures. An insurer shall include a summary of its utilization review procedures in materials intended for prospective covered persons. An insurer shall print on its membership cards a toll-free telephone number to call for utilization review purposes.

(n) Maintenance of Records. — Every insurer and URO shall maintain records of each review performed and each appeal received or reviewed, as well as documentation sufficient to demonstrate compliance with this section. The maintenance of these records, including electronic reproduction and storage, shall be governed by rules adopted by the Commissioner that apply to insurers. These records shall be retained by the insurer and URO for a period of three years or until the Commissioner has adopted a final report of a general examination that contains a review of these records for that calendar year, whichever is later.

(o) Violation. — A violation of this section subjects an insurer to G.S. 58-2-70. (1997-443, s. 11A.122; 1997-519, s. 4.1.)

Editor's Note. — Session Laws 1997-443, s. 1.1, provides "This act shall be known as "The Current Operations and Capital Improvements Appropriations Act of 1997.'"

Session Laws 1997-443, s. 35.4, is a severability clause.

Session Laws 1997-519, s. 5, made this section effective January 1, 1998.

Session Laws 1997-519, s. 5, provides: "This act becomes effective January 1, 1998. Part II of this act applies to all health benefit plans that are delivered, issued for delivery, or renewed on or after January 1, 1998. For the purposes of this act, renewal of a health benefit plan is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the health benefit plan. Insurers other than health maintenance organizations that are subject to Part IV of this act have until July 1, 1998, to implement the procedures for grievances that are contained in Section 4.2 of Part IV of this act; provided, however, that insurers other than health maintenance organizations shall comply with the second-level grievance review procedures in Section 4.2 of Part IV of this act for appeals of noncertifications effective January 1, 1998."

Effect of Amendments. — Session Laws 1997-443, s. 11A.122, effective August 28, 1997, substituted "Health and Human Services" for "Human Resources" in subdivision (a)(7).

§ 58-50-62. Insurer grievance procedures.

(a) Purpose and Intent. — The purpose of this section is to provide standards for the establishment and maintenance of procedures by insurers to assure that covered persons have the opportunity for appropriate resolutions of their grievances.

(b) Availability of Grievance Process. — Every insurer shall have a grievance process whereby a covered person may voluntarily request a review of any decision, policy, or action of the insurer that affects that covered person. The grievance process may provide for an immediate informal consideration by the insurer of a grievance. If the insurer does not have a procedure for informal consideration or if an informal consideration does not resolve the grievance, the grievance process shall provide for first-and second-level reviews of grievances; except that an appeal of a noncertification that has been reviewed under G.S. 58-50-61 shall be reviewed as a second-level grievance under this section.

(c) Grievance Procedures. — Every insurer shall have written procedures for receiving and resolving grievances from covered persons. A description of the grievance procedures shall be set forth in or attached to the certificate of coverage and member handbook provided to covered persons. The description shall include a statement informing the covered person that the grievance procedures are voluntary and shall also inform the covered person about the availability of the Commissioner's office for assistance, including the telephone number and address of the office.

(d) Maintenance of Records. — Every insurer shall maintain records of each grievance received and the insurer's review of each grievance, as well as documentation sufficient to demonstrate compliance with this section. The maintenance of these records, including electronic reproduction and storage, shall be governed by rules adopted by the Commissioner that apply to insurers. The insurer shall retain these records for three years or until the Commissioner has adopted a final report of a general examination that contains a review of these records for that calendar year, whichever is later.

(e) First-Level Grievance Review. — A grievance may be submitted by a covered person or his or her provider acting on the covered person's behalf.

(1) The insurer does not have to allow a covered person to attend the first-level grievance review. A covered person may submit written material. Within three business days after receiving a grievance, the insurer shall provide the covered person with the name, address, and telephone number of the coordinator and information on how to submit written material.

(2) An insurer shall issue a written decision to the covered person and, if applicable, to the covered person's provider, within 30 days after receiving a grievance. The person or persons reviewing the grievance shall not be the same person or persons who initially handled the matter that is the subject of the grievance and, if the issue is a clinical one, at least one of whom shall be a medical doctor with appropriate expertise to evaluate the matter. The written decision issued in a first-level grievance review shall contain:

a. The professional qualifications and licensure of the person or persons reviewing the grievance.

b. A statement of the reviewers' understanding of the grievance.

c. The reviewers' decision in clear terms and the contractual basis or medical rationale in sufficient detail for the covered person to respond further to the insurer's position.

d. A reference to the evidence or documentation used as the basis for the decision.

e. A statement advising the covered person of his or her right to request a second-level grievance review and a description of the procedure for submitting a second-level grievance under this section.

(f) Second-Level Grievance Review. — An insurer shall establish a second-level grievance review process for covered persons who are dissatisfied with the first-level grievance review decision or a utilization review appeal decision.

(1) An insurer shall, within 10 business days after receiving a request for a second-level grievance review, make known to the covered person:
  a. The name, address, and telephone number of a person designated to coordinate the grievance review for the insurer.
  b. A statement of a covered person's rights, which include the right to request and receive from an insurer all information relevant to the case; attend the second-level grievance review; present his or her case to the review panel; submit supporting materials before and at the review meeting; ask questions of any member of the review panel; and be assisted or represented by a person of his or her choice, which person may be without limitation to: a provider, family member, employer representative, or attorney. If the covered person chooses to be represented by an attorney, the insurer may also be represented by an attorney.

(2) An insurer shall convene a second-level grievance review panel for each request. The panel shall comprise persons who were not previously involved in any matter giving rise to the second-level grievance, are not employees of the insurer or URO, and do not have a financial interest in the outcome of the review. A person who was previously involved in the matter may appear before the panel to present information or answer questions. All of the persons reviewing a second-level grievance involving a noncertification or a clinical issue shall be providers who have appropriate expertise, including at least one clinical peer. Provided, however, an insurer that uses a clinical peer on an appeal of a noncertification under G.S. 58-50-61 or on a first-level grievance review panel under this section may use one of the insurer's employees on the second-level grievance review panel in the same matter if the second-level grievance review panel comprises three or more persons.

(g) Second-Level Grievance Review Procedures. — An insurer's procedures for conducting a second-level grievance review shall include:

(1) The review panel shall schedule and hold a review meeting within 45 days after receiving a request for a second-level review.

(2) The covered person shall be notified in writing at least 15 days before the review meeting date.

(3) The covered person's right to a full review shall not be conditioned on the covered person's appearance at the review meeting.

(h) Second-Level Grievance Review Decisions. — An insurer shall issue a written decision to the covered person and, if applicable, to the covered person's provider, within seven business days after completing the review meeting. The decision shall include:

(1) The professional qualifications and licensure of the members of the review panel.

(2) A statement of the review panel's understanding of the nature of the grievance and all pertinent facts.

(3) The review panel's recommendation to the insurer and the rationale behind that recommendation.

(4) A description of or reference to the evidence or documentation considered by the review panel in making the recommendation.

(5) In the review of a noncertification or other clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the recommendation.

(6) The rationale for the insurer's decision if it differs from the review panel's recommendation.

(7) A statement that the decision is the insurer's final determination in the matter.

(8) Notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.

(i) Expedited Second-Level Procedures. — An expedited second-level review shall be made available where medically justified as provided in G.S. 58-50-61(l), whether or not the initial review was expedited. The provisions of subsections (f), (g), and (h) of this section apply to this subsection except for the following timetable: When a covered person is eligible for an expedited second-level review, the insurer shall conduct the review proceeding and communicate its decision within four days after receiving all necessary information. The review meeting may take place by way of a telephone conference call or through the exchange of written information.

(j) No insurer shall discriminate against any provider based on any action taken by the provider under this section or G.S. 58-50-61 on behalf of a covered person.

(k) Violation. — A violation of this section subjects an insurer to G.S. 58-2-70. (1997-519, s. 4.2.)

Editor's Note. — Session Laws 1997-519, s. 5, made this section effective January 1, 1998.

Session Laws 1997-519, s. 5, provides: "This act becomes effective January 1, 1998. Part II of this act applies to all health benefit plans that are delivered, issued for delivery, or renewed on or after January 1, 1998. For the purposes of this act, renewal of a health benefit plan is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the health benefit plan. Insurers other than health maintenance organizations that are subject to Part IV of this act have until July 1, 1998, to implement the procedures for grievances that are contained in Section 4.2 of Part IV of this act; provided, however, that insurers other than health maintenance organizations shall comply with the second-level grievance review procedures in Section 4.2 of Part IV of this act for appeals of noncertifications effective January 1, 1998."

§§ 58-50-63 through 58-50-64: Reserved for future codification purposes.

§ 58-50-65. Certain policies of insurance not affected.

(a) Nothing in Articles 50 through 55 of this Chapter shall apply to or affect any policy of liability or workers' compensation insurance, except that the provisions of G.S. 58-50-50 and subsections (b) and (c) of G.S. 58-50-55 shall apply to policies of workers' compensation insurance.

(b) Nothing in Articles 50 through 55 of this Chapter shall apply to or in any way affect contracts supplemental to contracts of life or endowment insurance where such supplemental contracts contain no provisions except such as operate to safeguard such insurance against lapse or to provide special benefits therefor in the event that the insured shall be totally, or totally and permanently disabled by reason of accidental bodily injury or by sickness, nor to contracts issued as supplements to life insurance contracts or contracts of endowment insurance, and intended to increase the amount insured by such life or endowment contracts in the event that the death or disability of the insured shall result from accidental bodily injuries: Provided, that no such supplemental contracts shall be issued or delivered to any person in this State unless and until a copy of the form thereof has been submitted to and approved by the Commissioner under such reasonable rules and regulations as he shall make concerning the provisions in such contracts, and their submission to and approval by him.

(c) Nothing in Articles 50 through 55 of this Chapter shall apply to or in any way affect fraternal benefit societies.

(d) The provisions of G.S. 58-51-5(5) and G.S. 58-51-15(a)(1), (4), and (10) may be omitted from railroad ticket policies sold only at railroad stations or at railroad ticket offices by railroad employees. (1911, c. 209, s. 5; 1913, c. 91, s. 12; C.S., s. 6489; 1921, c. 136, s. 5; 1945, c. 385; 1947, c. 721; 1991, c. 636, s. 3; c. 720, ss. 4, 42; 1993 (Reg. Sess., 1994), c. 679, s. 10.4; 1995, c. 193, s. 42.)

Editor's Note. — Sections 58-50-50 and 58-50-55 referred to above have been repealed.

Session Laws 1995, c. 193, s. 67 contains a severability clause.

§ 58-50-110. Definitions.

As used in this Act:

(1) "Accountable health carrier" means that as defined in G.S. 143-622(1).

(1a) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Commissioner that a small employer carrier is in compliance with the provisions of G.S. 58-50-130, and to the extent applicable, the provisions of Article 68 of this Chapter, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(1b) "Adjusted community rating" means a method used to develop carrier premiums which spreads financial risk across a large population and allows adjustments for the following demographic factors: age, gender, family composition, and geographic areas, as determined pursuant to G.S. 58-50-130(b).

(2) Repealed by Session Laws 1993, c. 529, s. 3.3.

(3) "Basic health care plan" means a health care plan for small employers that is lower in cost than a standard health care plan and is required to be offered by all small employer carriers pursuant to G.S. 58-50-125 and approved by the Commissioner in accordance with G.S. 58-50-125.

(4) "Board" means the board of directors of the Pool.

(5) "Carrier" means any person that provides one or more health benefit plans in this State, including a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization (HMO), and a multiple employer welfare arrangement.

(5a) "Case characteristics" means the demographic factors age, gender, family size, and geographic location.

(6), (7) Repealed by Session Laws 1993, c. 529, s. 3.3.

(8) "Committee" means the Small Employer Carrier Committee as created by G.S. 58-50-120.

(9) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health care plan covering the employee.

(10) "Eligible employee" means an employee who works for a small employer on a full-time basis, with a normal work week of 30 or more hours, including a sole proprietor, a partner or a partnership, or an independent contractor, if included as an employee under a health care plan of a small employer; but does not include employees who work on a part-time, temporary, or substitute basis.

(11) "Health benefit plan" means any accident and health insurance policy or certificate; nonprofit hospital or medical service corporation contract; health, hospital, or medical service corporation plan contract; HMO subscriber contract; plan provided by a MEWA or plan provided by another benefit arrangement, to the extent permitted by ERISA, subject to G.S. 58-50-115. Health benefit plan does not include benefits described in G.S. 58-68-25(b).

(12) "Impaired insurer" has the same meaning as prescribed in G.S. 58-62-20(6) or G.S. 58-62-16(8).

(13) Repealed by Session Laws 1993, c. 529, s. 3.3.

(14) "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer after the end of the initial enrollment period provided under the terms of the health benefit plan in effect at the time the employee first became eligible; provided that the initial enrollment period shall be a period of at least 30 consecutive calendar days. However, an eligible employee or dependent shall not be considered a late enrollee if:

a. The individual was covered under a public or private health benefit plan that provided, at the time the individual was eligible to enroll, benefits equal to or exceeding the same required level of benefits in the basic or standard health care plans adopted pursuant to G.S. 58-50-120 and either the individual:

1. Lost coverage under another health plan as a result of termination of employment, termination of a spouse's health plan coverage, or the death of a spouse or divorce and requests enrollment in a health benefit plan within 30 days after termination of coverage provided under another health plan; or
2. Stated, in writing, during the enrollment period that coverage under another employer health benefit plan was the reason for declining coverage;

a.3, 4. Repealed by Session Laws 1993, c. 529, s. 3.3.
b. The individual elects a different health plan offered through the Alliance during an open enrollment period;
c. An eligible employee requests enrollment within 30 days of becoming an employee of a member small employer;
d. A court has ordered coverage be provided for a spouse or minor child under a covered employee's health benefit plan and the request for enrollment for a spouse is made within 30 days after issuance of the court order. A minor child shall be enrolled in accordance with the requirements of G.S. 58-51-120; or
e. The individual or employee enrollee makes a request for enrollment of the spouse or child within 30 days after the individual's or employee's marriage or the birth, adoption, or placement for adoption of a child.

(15) Repealed by Session Laws 1993, c. 529, s. 3.3.

(16) "Pool" means the North Carolina Small Employer Health Reinsurance Pool created in G.S. 58-50-150.

(17) "Preexisting-conditions provision" means a preexisting-condition provision as defined in G.S. 58-68-30.

(18) "Premium" includes insurance premiums or other fees charged for a health benefit plan, including the costs of benefits paid or reimbursements made to or on behalf of persons covered by the plan.

(19) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier.

(20) "Risk-assuming carrier" means a small employer carrier electing to comply with the requirements set forth in G.S. 58-50-140.

(21) "Reinsuring carrier" means a small employer carrier electing to comply with the requirements set forth in G.S. 58-50-145.

(21a) "Self-employed individual" means an individual or sole proprietor who derives a majority of his or her income from a trade or business carried on by the individual or sole proprietor which results in taxable income as indicated on IRS form 1040, Schedule C or F and which generated taxable income in one of the two previous years.

(22) "Small employer" means any individual actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed no more than 50 eligible employees, the majority of whom are employed within this State, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this State, shall be considered one employer. Subsequent to the issuance of a health benefit plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, the provisions of this Act that apply to a small employer shall continue to apply until the

plan anniversary following the date the small employer no longer meets the requirements of this definition. For purposes of this Act, the term small employer includes self-employed individuals.

(23) "Small employer carrier" means any carrier that offers health benefit plans covering eligible employees of one or more small employers.

(24) "Standard health care plan" means a health care plan for small employers required to be offered by all small employer carriers under G.S. 58-50-125 and approved by the Commissioner in accordance with G.S. 58-50-125. (1991, c. 630, s. 1; 1993, c. 408, ss. 1, 2; c. 529, s. 3.3; 1993 (Reg. Sess., 1994), c. 569, s. 6; 1997-259, s. 2.)

Editor's Note. —

Session Laws 1997-259, s. 25, provides: "Sections 1 through 18 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after July 1, 1997. Sections 19, 20, 21, 22, and 23 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after January 1, 1998. For the purposes of this act, renewal of a contract is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the contract."

Effect of Amendments. — The 1997 amendment, effective July 1, 1997, in subdivision (1a) inserted "and to the extent applicable, the provisions of Article 68 of this Chapter" following "G.S. 58-50-130"; rewrote subdivision (11); in subdivision (14)a. substituted "benefits equal to or exceeding the same required level of benefits in the basic or" for "the same required level of benefits in the basic and" following "eligible to enroll"; in subdivision (14)a.1. substituted "health benefit plan" for "basic or standard health care plan" following "enrollment in a"; in subdivision (14)d. substituted "for a spouse is made within 30 days after issuance of the court order" for "is made within 30 days after issuance of the court order" following "request for enrollment", and added the last sentence; in subdivision (14)e. substituted "after the individual's or employee's marriage or the birth, adoption, or placement for adoption" for "of the individual or employee's marriage or the birth or adoption" following "within 30 days"; rewrote subdivision (17); and in subdivision (22) substituted "50" for "49" following "no more than". For applicability, see Editor's note.

§ 58-50-125. Health care plans; formation; approval; offerings.

(a) To improve the availability and affordability of health benefits coverage for small employers, the Committee shall recommend to the Commissioner two plans of coverage, one of which shall be a basic health care plan and the second of which shall be a standard health care plan. Each plan of coverage shall be in two forms, one of which shall be in the form of insurance and the second of which shall be consistent with the basic method of operation and benefit plans of HMOs, including federally qualified HMOs. On or before January 1, 1992, the Committee shall file a progress report with the Commissioner. The Committee shall submit the recommended plans to the Commissioner for approval within 180 days after the appointment of the Committee under G.S. 58-50-120. The Committee shall take into consideration the levels of health benefit plans provided in North Carolina, and appropriate medical and economic factors, and shall establish benefit levels, cost sharing, exclusions, and limitations. Notwithstanding subsection (c) of this section, in developing and approving the plans, the Committee and the Commissioner shall give due consideration to cost-effective and life-saving health care services and to cost-effective health care providers. The Committee shall file with the Commissioner its findings and recommendations, and reasons for the findings and recommendations, if it does not provide for coverage by any type of health care provider specified in G.S. 58-50-30. The recommended plans may include cost containment features such as, but not limited to: preferred provider provisions; utilization review of medical necessity of hospital and physician services; case management benefit alternatives; or other managed care provisions.

(b) After the Commissioner's approval of the plans submitted by the Committee under subsection (a) of this section and in lieu of any contrary procedure established by this Chapter, any small employer carrier may certify to the Commissioner, in the form and manner prescribed by the Commissioner, that the basic and standard health care plans filed by the carrier are in substantial compliance with the provisions of the corresponding approved Committee plans. Upon receipt by the Commissioner of the certification, the carrier may use the certified plans unless their use is disapproved by the Commissioner.

(c) Except as provided under Article 68 of this Chapter, the plans developed under this section are not required to provide coverage that meets the requirements of other provisions of this Chapter that mandate either coverage or the offer of coverage by the type or level of health care services or health care provider.

(d) Within 180 days after the Commissioner's approval under subsection (b) of this section, every small employer carrier shall, as a condition of transacting business in this State, offer small employers at least one basic and one standard health care plan. Every small employer that elects to be covered under such a plan and agrees to make the required premium payments and to satisfy the other provisions of the plan shall be issued such a plan by the small employer carrier. The premium payment requirements used in connection with basic and standard health care plans may address the potential credit risk of small employers that elect coverage in accordance with this subsection by means of payment security provisions that are reasonably related to the risk and are uniformly applied.

If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all eligible employees of a small employer and their dependents. A small employer carrier shall not offer coverage to only certain individuals in a small employer group except in the case of late enrollees as provided in G.S. 58-50-130(a)(4). A small employer carrier shall not modify any health benefit plan with respect to a small employer, any eligible employee, or dependent through riders, endorsements, or otherwise, in order to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan. In the case of an eligible employee or dependent of an eligible employee who, before the effective date of the plan, was excluded from coverage or denied coverage by a small employer carrier in the process of providing a health benefit plan to an eligible small employer, the small employer carrier shall provide an opportunity for the eligible employee or dependent of an eligible employee to enroll in the health benefit plan currently held by the small employer.

(e) No small employer carrier is required to offer coverage or accept applications under subsection (d) of this section:

(1) From a group already covered under a health benefit plan except for coverage that is to begin after the group's anniversary date, but this subsection shall not be construed to prohibit a group from seeking coverage or a small employer carrier from issuing coverage to a group before its anniversary date; or

(2) If the Commissioner determines that acceptance of an application or applications would result in the carrier being declared an impaired insurer.

(3) Repealed by Session Laws 1993, c. 529, s. 3.6, effective January 1, 1995.

(f) Every small employer carrier shall fairly market the basic and standard health care plan to all small employers in the geographic areas in which the carrier makes coverage available or provides benefits.

(g) No HMO operating as either a risk-assuming carrier or a reinsuring carrier is required to offer coverage or accept applications under subsection (d) of this section in the case of any of the following:

(1) To a group that is not physically located in the HMO's approved service areas;

(2) To an employee who does not reside within the HMO's approved service areas;

(3) Within an area, where the HMO can reasonably anticipate, and demonstrate, to the Commissioner's satisfaction, that it will not have the capacity within that area and its network of providers to deliver services adequately to the enrollees of those groups because of its obligations to existing group contract holders and enrollees.

An HMO that does not offer coverage pursuant to subdivision (3) of this subsection may not offer coverage in the applicable area to new employer groups with more than 49 eligible employees until the later of 90 days after that closure or the date on which the carrier notifies the Commissioner that it has regained capacity to deliver services to small employers.

(h) The provisions of subsections (b), (d), and (g) and subdivision (e)(2) of this section apply to every health benefit plan delivered, issued for delivery, renewed, or continued in this State or covering persons residing in this State on or after the date the plan becomes operational, as determined by the Commissioner. For purposes of this subsection, the date a health benefit plan is continued is the anniversary date of the issuance of the health benefit plan. (1991, c. 630, s. 1; c. 761, s. 10; 1993, c. 529, s. 3.6; 1997-259, ss. 3, 4.)

Editor's Note. —

Session Laws 1997-259, s. 25, provides: "Sections 1 through 18 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after July 1, 1997. Sections 19, 20, 21, 22, and 23 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after January 1, 1998. For the purposes of this act, renewal of a contract is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the contract."

Effect of Amendments. — Session Laws 1997-259, ss. 3 and 4, effective July 1, 1997, substituted "Except as provided under Article 68 of this Chapter, the" for "The" at the beginning of subsection (c); and appear to have made no change to subsection (g). For applicability, see Editor's note.

§ 58-50-130. Required health care plan provisions.

(a) Health benefit plans covering small employers are subject to the following provisions:

(1) to (4) Repealed by Session Laws 1997-259, s. 5, effective July 14, 1997.

(4a) A carrier may continue to enforce reasonable employer participation and contribution requirements on small employers applying for coverage; however, participation and contribution requirements may vary among small employers only by the size of the small employer group and shall not differ because of the health benefit plan involved. In applying minimum participation requirements to a small employer, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage in determining whether an applicable participation level is met. "Qualifying existing coverage" means benefits or coverage provided under: (i) Medicare, Medicaid, and other government funded programs; or (ii) an employer-based health insurance or health benefit arrangement, including a self-insured plan, that provides benefits similar to or in excess of benefits provided under the basic health care plan. An accountable health carrier shall not enforce participation or contribution requirements on member small employers, as defined in G.S. 143-622(18), unless those requirements meet with the standards adopted by the State Health Plan Purchasing Alliance Board.

(5) Notwithstanding any other provision of this Chapter, no small employer carrier, insurer, subsidiary of an insurer, or controlled individual of an insurance holding company shall act as an administrator or claims paying agent, as opposed to an insurer, on behalf of small groups which, if they purchased insurance, would be subject to this section. No small employer carrier, insurer, subsidiary of an insurer, or controlled individual of an insurance holding company shall provide stop loss, catastrophic, or reinsurance coverage to small employers that does not comply with the underwriting, rating, and other applicable standards in this Act.

(6) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all eligible employees of a small employer and their dependents. A small employer carrier shall not offer coverage to only certain individuals in a small employer group except in the case of late enrollees as provided in G.S. 58-50-130(a)(4).

(7), (8) Repealed by Session Laws 1997-259, s. 5, effective July 14, 1997.

(9) The health benefit plan must meet the applicable requirements of Article 68 of this Chapter.

(b) For all small employer health benefit plans that are subject to this section, premium rates for health benefit plans subject to this section are subject to the following provisions:

(1) Small employer carriers shall use an adjusted- community rating methodology in which the premium for each small employer can vary only on the basis of the eligible employ-

ee's or dependent's age as determined in accordance with subdivision (6) of this subsection, the gender of the eligible employee or dependent, number of family members covered, or geographic area as determined under subdivision (7) of this subsection. Premium rates charged during a rating period to small employers with similar case characteristics for same coverage shall not vary from the adjusted community rate by more than twenty percent (20%) for any reason, including differences in administrative costs and claims experience.

(2) Rating factors related to age, gender, number of family members covered, or geographic location may be developed by each carrier to reflect the carrier's experience. The factors used by carriers are subject to the Commissioner's review;

(3) Small employer carriers shall not modify the rate for a small employer for 12 months from the initial issue date or renewal date, unless the group is composite rated and composition of the group changed by twenty percent (20%) or more or benefits are changed. The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

a. The percentage change in the adjusted community rate as measured from the first day of the prior rating period to the first day of the new rating period, and

b. Any adjustment, not to exceed fifteen percent (15%) annually, due to claim experience, health status, or duration of coverage of the employees or dependents of the small employer, and

c. Any adjustment because of change in coverage or change in case characteristics of the small employer group.

(4), (5) Repealed by Session Laws 1995, c. 238, s. 1, effective June 13, 1995.

(6) For the purposes of subsection (b) of this section, a small employer carrier shall, unless the employer uses composite rating, use the following age brackets:

a. Younger than 15 years;
b. 15 to 19 years;
c. 20 to 24 years;
d. 25 to 29 years;
e. 30 to 34 years;
f. 35 to 39 years;
g. 40 to 44 years;
h. 45 to 49 years;
i. 50 to 54 years;
j. 55 to 59 years;
k. 60 to 64 years;
l. 65 years.

Carriers may combine, but shall not split, complete age brackets for the purposes of determining rates under subsection (b) of this section. Small employer carriers shall be permitted to develop separate rates for individuals aged 65 years and older for coverage for which Medicare is the primary payor and coverage for which Medicare is not the primary payor.

(7) For the purposes of subsection (b) of this section, a carrier shall not apply different geographic rating factors to the

rates of small employers located within the same county; and

(8) The Department may adopt rules to administer this subsection and to assure that rating practices used by small employer carriers are consistent with the purposes of this subsection. Those rules shall include consideration of differences based on the following:

a. Health benefit plans that use different provider network arrangements may be considered separate plans for the purposes of determining the rating in subdivision (1) of this subsection, provided that the different arrangements are expected to result in substantial differences in claims costs;

b. Except as provided for in sub-subdivision a. of this subdivision, differences in rates charged for different health benefit plans shall be reasonable and reflect objective differences in plan design, but shall not permit differences in premium rates because of the case characteristics of groups assumed to select particular health benefit plans; and

c. Small employer carriers shall apply allowable rating factors consistently with respect to all small employers.

(c) Repealed by Session Laws 1993, c. 529, s. 3.7, effective January 1, 1995.

(d) In connection with the offering for sale of any health benefit plan to a small employer, each small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of the following and shall provide this information to the small employer upon request:

(1) Repealed by Session Laws 1993, c. 529, s. 3.7.

(2) Provisions concerning the small employer carrier's right to change premium rates and the factors other than claims experience that affect changes in premium rates.

(3) Provisions relating to renewability of policies and contracts.

(4) Provisions affecting any preexisting conditions provision.

(5) The benefits available and premiums charged under all health benefit plans for which the small employer is eligible.

(e) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(f) Each small employer carrier shall file with the Commissioner annually on or before March 15 an actuarial certification certifying that it is in compliance with this Act and that its rating methods are actuarially sound. The small employer carrier shall retain a copy of the certification at its principal place of business.

(g) A small employer carrier shall make the information and documentation described in subsection (e) of this section available to the Commissioner upon request. Except in cases of violations of this Act, the information is proprietary and trade secret information and is not subject to disclosure by the Commissioner to persons outside of the Department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

(h) The provisions of subdivisions (a)(1), (3), and (5) and subsections (b) through (g) of this section apply to health benefit plans delivered, issued for delivery, renewed, or continued in this State or covering persons residing in this State on or after January 1, 1992. The provisions of subdivisions (a)(2) and (4) of this section apply to health benefit plans delivered, issued for delivery, renewed, or continued in this State or covering persons residing in this State on or after the date the plan becomes operational, as designated by the Commissioner. For purposes of this subsection, the date a health benefit plan is continued is the anniversary date of the issuance of the health benefit plan. (1991, c. 630, s. 1; 1993, c. 408, s. 6; c. 529, ss. 3.2, 3.7; 1993 (Reg. Sess., 1994), c. 569, ss. 7, 8; c. 678, ss. 24, 25; 1995, c. 238, s. 1; c. 507, s. 23A.1(b); 1995 (Reg. Sess., 1996), c. 669, s. 1; 1997-259, ss. 5, 6.)

Editor's Note. —

Session Laws 1995, c. 238, s. 5, provides in part that the Small Group Carrier Committee, the Department of Insurance, and the State Health Plan Purchasing Alliance Board shall report to the Joint Legislative Commission on Governmental Operations no later than January 1, 1997 on issues related to adjusted community ratings.

Session Laws 1995, c. 507, s. 1.1, provides that this act shall be known and cited as the Expansion and Capital Improvements Appropriations Act of 1995.

Session Laws 1995, c. 507, s. 28.12 is a severability clause.

Session Laws 1997-259, s. 25, provides: "Sections 1 through 18 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after July 1, 1997. Sections 19, 20, 21, 22, and 23 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after January 1, 1998. For the purposes of this act, renewal of a contract is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the contract."

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective June 21, 1996, in subdivision (a)(2), deleted "group" following "covered under a previous" in the first sentence, and in the last sentence, substituted "the meaning of 'health benefit plan' is not limited to the definition in G.S. 58-50-115, but includes any health benefit plan provided by a health insurer, as that term is defined in G.S. 58-51-115(a), or any government plan or program providing health benefits or health care" for "'health benefit plan' is not limited to plans subject to this act under G.S. 58-50-115."

Session Laws 1997-259, ss. 5 and 6, effective July 1, 1997, deleted subdivisions (a)(1) through (a)(4) concerning preexisting conditions provisions, renewability, and late enrollees, deleted subdivisions (a)(7) and (a)(8) concerning modifications or exclusions by small employer carriers, and added subdivision (a)(9); and in subsection (d) inserted "the following and shall provide this information to the small employer upon request" in the introductory language, and added subdivision (d)(5). For applicability, see Editor's note.

§ 58-50-149. Limit on cessions to the Reinsurance Pool.

In addition to any individual or group previously reinsured in accordance with G.S. 58-50-150(g)(1), the Pool shall only reinsure a health benefit plan issued or delivered for original issue by a reinsuring carrier on or after October 1, 1995, if the health benefit plan provides coverage to a small employer with no more than 25 eligible employees, including self-employed individuals. (1995, c. 517, s. 29.)

Editor's Note. — Session Laws 1995, c. 517, s. 42, made this section effective October 1, 1995.

Session Laws 1995, c. 517, s. 41, contains a severability clause.

§ 58-50-150. North Carolina Small Employer Health Reinsurance Pool.

Legal Periodicals. — For article, "Toward Full Participation and Protection of the Worker with Illness: The Failure of Federal Health Law After McGann v. H & H Music Co.," see 29 Wake Forest L. Rev. 781 (1994).

§ 58-50-155. Standard and basic health care plan coverages.

(a) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for mammograms and pap smears at least equal to the coverage required by G.S. 58-51-57.

(a1) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer at least equal to the coverage required by G.S. 58-51-58.

(a2) Notwithstanding G.S. 58-50-123(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for reconstructive breast surgery resulting from a mastectomy at least equal to the coverage required by G.S. 58-51-62.

(b) Notwithstanding G.S. 58-50-125(c), in developing and approving the plans under G.S. 58-50-125, the Committee and Commissioner shall give due consideration to cost-effective and life-saving health care services and to cost-effective health care providers. This section shall be effective after July 10, 1991. (1991, c. 490, s. 5; 1993, c. 269, s. 4; 1997-312, s. 4; 1997-456, s. 40(b).)

Editor's Note. —

Session Laws 1997-312, s. 6, provides: "Nothing in this act shall apply to specified accident, specified disease, hospital indemnity, or long-term care health insurance policies."

Effect of Amendments. — Session Laws 1997-312, s. 4, effective January 1, 1998, added subsection (a2).

Session Laws 1997-456, s. 40(b), effective January 1, 1998, substituted "G.S. 58-51-62" for "G.S. 58-51-61" in subsection (a2).

ARTICLE 51.

Nature of Policies.

§ 58-51-15. Accident and health policy provisions.

(a) Required Provisions. — Except as provided in subsection (c) of this section each such policy delivered or issued for delivery to any person in this State shall contain the provisions specified in this subsection in the substance of the words that appear in this section. Such provisions shall be preceded individually by the caption appearing in this subsection or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the Commissioner may approve.

(1) A provision in the substance of the following language:

ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or waive any of its provisions.

(2) A provision in the substance of the following language:

TIME LIMIT ON CERTAIN DEFENSES:

a. After two years from the date of issue or reinstatement of this policy no misstatements except fraudulent misstatements made by the applicant in the application for such policy shall be used to void the policy or deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two-year period.

The foregoing policy provision may be used in its entirety only in major or catastrophe hospitalization policies and major medical policies each affording benefits of five thousand dollars ($5,000) or more for any one sickness or injury; disability income policies affording benefits of one hundred dollars ($100.00) or more per month for not less than 12 months; and franchise policies.. Other policies to which this section applies must delete the words "except fraudulent misstatements."

(The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period, nor to limit the application of G.S. 58-51-15(b), (1), (2), (3), (4) and (5) in the event of misstatement with respect to age or occupation or other insurance.)

(A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium:

1. Until at least age 50 or,
2. In the case of a policy issued after age 44, for at least five years from its date of issue, may contain in lieu of the foregoing the following provisions (from which the clause in parentheses may be omitted at the insurer's option) under the caption "INCONTESTABLE."

After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.)

b. This policy contains a provision limiting coverage for preexisting conditions. Preexisting conditions are covered under this policy .... (insert number of months or days, not to exceed one year) after the effective date of coverage. Preexisting conditions mean "those conditions for which medical advice, diagnosis, care, or treatment was received or recommended within the one-year period immediately preceding the effective date of the person's coverage." Credit for having satisfied some or all of the preexisting condition waiting periods under previous health benefits coverage shall be given in accordance with G.S. 58-68-30.

(3) A provision in the substance of the following language:

GRACE PERIOD: A grace period of .... (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

(A policy which contains a cancellation provision may add, at the end of the above provision, subject to the right of the insurer to cancel in accordance with the cancellation provision hereof.

A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision,

Unless not less than five days prior to the premium due date the insurer has delivered to the insured or has mailed to his last address as shown by the record of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted.)

(4) A provision in the substance of the following language:

REINSTATEMENT: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer, or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

(The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums:

a. Until at least age 50 or,

b. In the case of a policy issued after age 44, for at least five years from its date of issue.)

(5) A provision in the substance of the following language:

NOTICE OF CLAIM: Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at .... (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

(In a policy providing a loss-of-time benefit which may be payable for at least two years, an insurer may at its option insert the following between the first and second sentences of the above provision:

Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, he shall, at least once in every six months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given.)

(6) A provision in the substance of the following language:

CLAIM FORMS: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

(7) A provision in the substance of the following language:

PROOFS OF LOSS: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

(8) A provision in the substance of the following language:

TIME OF PAYMENT OF CLAIMS: Indemnities payable under this policy for any loss other than loss for which this policy provides any period payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid ...... (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

(9) A provision in the substance of the following language:

PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

(The following provisions, or either of them, may be included with the foregoing provision at the option of the insurer:

If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $........ (insert an amount which shall not exceed three thousand dollars ($3,000)), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services, may at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.)

(10) A provision in the substance of the following language:

PHYSICAL EXAMINATIONS AND AUTOPSY: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

(11) A provision in the substance of the following language:

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

(12) A provision in the substance of the following language:

CHANGE OF BENEFICIARY: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

(The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.)

(b) Other Provisions. — Except as provided in subsection (c) of this section, no such policy delivered or issued for delivery to any person in this State shall contain provisions respecting the matters set forth below unless such provisions are in the substance of the words that appear in this section. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in this subsection or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the Commissioner may approve.

(1) A provision in the substance of the following language:

CHANGE OF OCCUPATION: If the insured be injured or contract sickness after having changed his occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes his occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

(2) A provision in the substance of the following language:

MISSTATEMENT OF AGE: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

(3) A provision in the substance of the following language:

OTHER INSURANCE IN THIS INSURER: If an accident or health or accident and health policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for .... (insert type of coverage or coverages) in excess of $........ (insert maximum limit of indemnity or indemnities) the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to his estate.

Or, in lieu thereof:

Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, his beneficiary or his estate, as the case may be, and the insurer will return all premiums paid for all other such policies.

(4) A provision in the substance of the following language:

INSURANCE WITH OTHER INSURERS: If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

(If the foregoing policy provision is included in a policy which also contains the next following policy provision there shall be added to the caption of the foregoing provision the phrase "... EXPENSE INCURRED BENEFITS." The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the Commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the Commissioner. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provisions no third-party liability coverage shall be included as "other valid coverage.")

(5) A provision in the substance of the following language:

INSURANCE WITH OTHER INSURERS: If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined.

(If the foregoing policy provision is included in a policy which also contains the next preceding policy provision there shall be added to the caption of the foregoing provision the phrase "... OTHER BENEFITS." The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the Commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage the inclusion of which may be approved by the Commissioner. In the absence of such definition such term shall not include group insurance, or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third-party liability coverage shall be included as "other valid coverage.")

(6) A provision in the substance of the following language:

RELATION OF EARNINGS TO INSURANCE: If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his average monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two years as shall exceed the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of two hundred dollars ($200.00) or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time.

(The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums:

a. Until at least age 50 or,
b. In the case of a policy issued after age 44, for at least five years from its date of issue.

The insurer may, at its option, include in this provision a definition of "valid loss of time coverage," approved as to form by the Commissioner, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the Commissioner or any combination of such coverages. In the absence of such definition such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations.)

(7) A provision in the substance of the following language:

UNPAID PREMIUM: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

(8) Repealed by Session Laws 1955, c. 886, s. 1.

(9) A provision in the substance of the following language:

CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

(10) A provision in the substance of the following language:

ILLEGAL OCCUPATION: The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

(11) A provision in the substance of the following language:

INTOXICANTS AND NARCOTICS: Except for the payment of benefits for the necessary care and treatment of chemical dependency as provided by law, the insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

(c) Inapplicable or Inconsistent Provisions. — If any provision of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy the insurer, with the approval of the Commissioner, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

(d) Order of Certain Policy Provisions. — The provisions which are the subject of subsections (a) and (b) of this section, or any corresponding provisions which are used in lieu thereof in accordance with such subsections, shall be printed in the consecutive order of the provisions in such subsections or, at the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued.

(e) Third-Party Ownership. — The word "insured," as used in Articles 50 through 55 of this Chapter shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits and rights provided therein.

(f) Requirements of Other Jurisdictions.

(1) Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this State, may contain any provision which is not less favorable to the insured or the beneficiary than the provisions of Articles 50 through 55 of this Chapter and which is prescribed or required by the law of the state under which the insurer is organized.

(2) Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such other state or country.

(g) Filing Procedure. — The Commissioner may make such reasonable rules and regulations concerning the procedure for the filing or submission of policies subject to Articles 50 through 55 of this Chapter as are necessary, proper or advisable to the administration of Articles 50 through 55 of this Chapter. This provision shall not abridge any other authority granted the Commissioner by law.

(h) Preexisting Condition Exclusion Clarification. — Sub-subdivision (a)(2)b. of this section does not apply to:

(1) Policies issued to eligible individuals under G.S. 58-68-60.

(2) Excepted benefits as described in G.S. 58-68-25(b). (1953, c. 1095, s. 2; 1955, c. 850, s. 8; c. 886, s. 1; 1961, c. 432; 1979, c. 755, ss. 9-12; 1983 (Reg. Sess., 1984), c. 1110, s. 13; 1987, c. 864, s. 42; 1987 (Reg. Sess., 1988), c. 975, s. 2; 1991, c. 636, s. 3; c. 720, s. 35; 1993, c. 506, s. 4; c. 553, s. 17; 1995, c. 507, s. 23A.1(g); 1995 (Reg. Sess., 1996), c. 742, s. 27; 1997-259, ss. 7, 7.1.)

Editor's Note. —

Session Laws 1995, c. 507, s. 1.1, provides that this act shall be known and cited as the Expansion and Capital Improvements Appropriations Act of 1995.

Session Laws 1995, c. 507, s. 28.12 is a severability clause.

Session Laws 1997-259, s. 25, provides: "Sections 1 through 18 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after July 1, 1997. Sections 19, 20, 21, 22, and 23 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after January 1, 1998. For the purposes of this act, renewal of a contract is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the contract."

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective June 21, 1996, in the second paragraph of subdivision (a)(2)a., substituted "provision" for "provisions", substituted "injury; disability" for "injury. Disability", and made a punctuation change.

Session Laws 1997-259, ss. 7 and 7.1, effective July 1, 1997, rewrote subdivision (a)(2)b., and added subsection (h). For applicability, see Editor's note.

§ 58-51-38. Direct access to obstetrician-gynecologists.

(a) Each health benefit plan shall allow each female plan participant or beneficiary age 13 or older direct access within the health benefit plan, without prior referral, to the health care services of an obstetrician-gynecologist participating in the health benefit plan, within the benefits provided under that health benefit plan pertaining to obstetrician-gynecologist services.

For purposes of this section:

(1) "Health benefit plan" means an HMO subscriber contract or any preferred provider, exclusive provider, or other managed care arrangement offered under a health benefit plan, as defined in G.S. 58-50-110(11).

(2) "Health care services" means the full scope of medically necessary services provided by the participating obstetrician-gynecologist in the care of or related to the female reproductive system and breasts, and in performing annual screening, counseling, and immunization for disorders and diseases in accordance with the most current published recommendations of the American College of Obstetricians and Gynecologists, and includes services provided by nurse practitioners, physician's assistants, and certified nurse midwives in collaboration with the obstetrician-gynecologist in the care of the participant or beneficiary.

(3) "Benefits" are those medical services or other items to which an individual is entitled under the terms of her contract with a health benefit plan, as approved by the Department of Insurance.

(b) Each health benefit plan shall inform female participants and beneficiaries in writing of the provisions of this section. The information shall be provided in benefit handbooks and materials and enrollment materials. (1995, c. 63, s. 1.)

Editor's Note. — Session Laws 1995, c. 63, s. 2, made this section effective January 1, 1996, and applicable to health benefit plans issued, renewed, or amended on or after that date. Section 2 further provided that for purposes of this section, renewal is presumed to occur on each anniversary of the date when coverage was first effective on the person or persons covered by the plan.

§ 58-51-55. No discrimination against the mentally ill and chemically dependent.

(a) Definitions. — As used in this section, the term:

(1) "Mental illness" has the same meaning as defined in G.S. 122C-3(21); and

(2) "Chemical dependency" has the same meaning as defined in G.S. 58-51-50

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders DSM-3-R or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) Coverage of Physical Illness. — No insurance company licensed in this State under this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

(1) Refuse to issue or deliver to that individual any policy that affords benefits or coverages for any medical treatment or service for physical illness or injury;
(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or
(3) Reduce physical illness or injury coverages or benefits for that individual.

(b1) Coverage of Mental Illness. — A policy that covers both physical illness or injury and mental illness may not impose a lesser lifetime or annual dollar limitation on the mental health benefits than on the physical illness or injury benefits, subject to the following:

(1) A lifetime limit or annual limit may be made applicable to all benefits under the policy, without distinguishing the mental health benefits.
(2) If the policy contains lifetime limits only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the policy, the insurer may impose a lifetime limit on the mental health benefits that is based on a weighted average of the respective lifetime limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.
(3) If the policy contains annual limits only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the policy, the insurer may impose an annual limit on the mental health benefits that is based on a weighted average of the respective annual limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.
(4) Except as otherwise provided in this section, the policy may distinguish between mental illness benefits and physical injury or illness benefits with respect to other terms of the policy, including coinsurance, limits on provider visits or days of coverage, and requirements relating to medical necessity.
(5) If the insurer offers two or more benefit package options under a policy, each package must comply with this subsection.
(6) This subsection does not apply to a policy if the insurer can demonstrate to the Commissioner that compliance will increase the cost of the policy by one percent (1%) or more.
(7) This subsection expires October 1, 2001, but the expiration does not affect services rendered before that date.

(c) Mental Illness or Chemical Dependency Coverage Not Required. — Nothing in this section requires an insurer to offer coverage for mental illness or chemical dependency, except as provided in G.S. 58-51-50.

(d) Applicability. — Subsection (b1) of this section applies only to group health insurance contracts covering more than 50 employees. The remainder of this section applies only to group health insurance contracts covering 20 or more employees. For purposes of this section, "group health insurance contracts" include MEWAs, as defined in G.S. 58-49-30(a). (1989, c. 369, s. 3; 1991, c. 720, s. 81; 1997-259, s. 21.)

Editor's Note. — Session Laws 1997-259, s. 25, provides: "Sections 1 through 18 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after July 1, 1997. Sections 19, 20, 21, 22, and 23 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after January 1, 1998. For the purposes of this act, renewal of a contract is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the contract."

Effect of Amendments. — The 1997 amendment, effective July 1, 1997, in subsection (a) added the subcatchline "Definitions"; in subsection (b) added the subcatchline "Coverage of Physical Illness", deleted "the provisions of Articles 1 through 64 of" preceding "this Chapter shall"; added subsection (b1); and rewrote subsections (c) and (d). For applicability, see Editor's note.

§ 58-51-57. Coverage for mammograms and pap smears.

(a) Every policy or contract of accident or health insurance, and every preferred provider benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1992, shall provide coverage for pap smears and for low-dose screening mammography. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for pap smears and low-dose screening mammography.

(b) As used in this section, "low-dose screening mammography" means a radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography, including a physician's interpretation of the results of the procedure.

(c) Coverage for low-dose screening mammography shall be provided as follows:

(1) One or more mammograms a year, as recommended by a physician, for any woman who is at risk for breast cancer. For purposes of this subdivision, a woman is at risk for breast cancer if any one or more of the following is true:
   a. The woman has a personal history of breast cancer;
   b. The woman has a personal history of biopsy-proven benign breast disease;
   c. The woman's mother, sister, or daughter has or has had breast cancer; or
   d. The woman has not given birth prior to the age of 30;

(2) One baseline mammogram for any woman 35 through 39 years of age, inclusive;

(3) A mammogram every other year for any woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a physician; and

(4) A mammogram every year for any woman 50 years of age or older.

(d) Reimbursement for a mammogram authorized under this section shall be made only if the facility in which the mammogram was performed meets mammography accreditation standards. Mammography accreditation standards shall be those established by the North Carolina Medical Care Commission unless such standards are not in effect, in which case standards established by the United States Department of Health and Human Services for Medicare/Medicaid coverage of screening mammography shall apply until Medical Care Commission standards become effective. Facilities that do not meet required mammography accreditation standards shall so inform the patient or the patient's legally responsible person prior to performing the mammogram.

(e) Coverage for pap smears shall be provided for pap smears obtained once a year, or more frequently if recommended by a physician. Coverage shall include the examination, the laboratory fee, and the physician's interpretation of the laboratory results. When the screening pap smear accreditation standards adopted by the North Carolina Medical Care Commission become effective, reimbursement for laboratory fees shall be made only if the laboratory meets those standards. Facilities utilizing services of laboratories that do not meet accreditation standards for screening pap smears shall, prior to performing the pap smear examination, inform the patient or the patient's legally responsible person that such laboratory fees will not be covered. (1991, c. 490, s. 1; 1997-519, s. 3.3.)

Effect of Amendments. — The 1997 amendment, effective January 1, 1998, substituted "benefit plan under G.S. 58-50-56" for "contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55" in subsection (a).

§ 58-51-58. Coverage for prostate-specific antigen (PSA) tests.

(a) Every policy or contract of accident and health insurance, and every preferred provider benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1994, shall provide coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer.

(b) As used in this section, "prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer" means serological tests for determining the presence of prostate cytoplasmic protein (PSA) and the generation of antibodies to it, as a novel marker for prostatic disease.

(c) Coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer shall be provided when recommended by a physician. (1993, c. 269, s. 1; 1997-519, s. 3.4.)

Effect of Amendments. — The 1997 amendment, effective January 1, 1998, substituted "benefit plan under G.S. 58-55-56" for "contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55" in subsection (a).

§ 58-51-59. Coverage of certain prescribed drugs for cancer treatment.

(a) No policy or contract of accident or health insurance, and no preferred provider benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1994, and that provides coverage for prescribed drugs approved by the federal Food and Drug Administration for the treatment of certain types of cancer shall exclude coverage of any drug on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the federal Food and Drug Administration. The drug, however, must be approved by the federal Food and Drug Administration and must have been proven effective and accepted for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia:

(1) The American Medical Association Drug Evaluations;
(2) The American Hospital Formulary Service Drug Information; or
(3) The United States Pharmacopeia Drug Information.

(b) Notwithstanding subsection (a) of this section, coverage shall not be required for any experimental or investigational drugs or any drug that the federal Food and Drug Administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed.

(c) This section shall apply only to cancer drugs and nothing in this section shall be construed, expressly or by implication, to create, impair, alter, limit, notify, enlarge, abrogate, or prohibit reimbursement for drugs used in the treatment of any other disease or condition. (1993, c. 506, s. 4.1; 1997-519, s. 3.5.)

Effect of Amendments. — The 1997 amendment, effective January 1, 1998, substituted "benefit plan under G.S. 58-55-56" for "contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55" in subsection (a).

§ 58-51-61. Coverage for certain treatment for diabetes.

(a) Every policy or contract of accident or health insurance, and every preferred provider benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after October 1, 1997, shall provide coverage for medically appropriate and necessary services, including diabetes outpatient self-management training and educational services, and equipment, supplies, medications, and laboratory procedures used to treat diabetes. Diabetes outpatient self-management training and educational services shall be provided by a physician or a health care professional designated by the physician. The insurer shall determine who shall provide and be reimbursed for the diabetes outpatient self-management training and educational services. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to the diabetes coverage required under this section.

(b) For the purposes of this section, "physician" is a person licensed to practice in this State under Article 1 or Article 7 of Chapter 90 of the General Statutes. (1997-225, s. 1; 1997-519, s. 3.11.)

Editor's Note. — Session Laws 1997-225, s. 6, made this section effective June 26, 1997.

Session Laws 1997-225, s. 4, provides: "Nothing in this act shall apply to specified accident, specified disease, hospital indemnity, or long-term care health insurance policies."

Effect of Amendments. — The 1997 amendment, effective January 1, 1998, substituted "benefit plan under G.S. 58-50-56" for "contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55" in subsection (a).

§ 58-51-62. Coverage for reconstructive breast surgery resulting from mastectomy.

(a) Every policy or contract of accident and health insurance, and every preferred provider benefit plan under G.S. 58-50-60 that is issued, renewed, or amended on or after January 1, 1998, and that provides coverage for mastectomy shall provide coverage for reconstructive breast surgery resulting from a mastectomy. The coverage shall include coverage for all stages and revisions of reconstructive breast surgery performed on a nondiseased breast to establish symmetry when reconstructive surgery on a diseased breast is performed. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for reconstructive breast surgery. Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction, subject to the approval of the treating physician.

(b) As used in this section, the following terms have the meanings indicated:

(1) "Mastectomy" means the surgical removal of all or part of a breast as a result of breast cancer or breast disease.

(2) "Reconstructive breast surgery" means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts, and includes reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple/areolar complex. "Reconstructive breast surgery" also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast.

(c) A policy, contract, or plan subject to this section shall not:

(1) Deny coverage described in subsection (a) of this section on the basis that the coverage is for cosmetic surgery;

(2) Deny to a woman eligibility or continued eligibility to enroll or to renew coverage under the terms of the contract, policy, or plan, solely for the purpose of avoiding the requirements of this section;

(3) Provide monetary payments or rebates to a woman to encourage her to accept less than the minimum protections available under this section;

(4) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider provided care to

an individual participant or beneficiary in accordance with this section; or

(5) Provide incentives, monetary or otherwise, to an attending provider to induce the provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section. (1997-312, s. 1; 1997-456, s. 40(a); 1997-519, s. 3.9.)

Editor's Note. — Section 58-50-60 referred to in subsection (a) has been repealed.

Session Laws 1997-312, s. 6, provides: "Nothing in this act shall apply to specified accident, specified disease, hospital indemnity, or long-term care health insurance policies."

Session Laws 1997-312, s. 7, made this section effective July 17, 1997.

Effect of Amendments. — Session Laws 1997-456, s. 40(a), effective retroactively to July 10, 1997, substituted "§ 58-51-62" for "§ 58-51-61" in the catchline.

Session Laws 1997-519, s. 3.9, effective January 1, 1998, substituted "benefit plan under G.S. 58-50-60" for "contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55" in subsecton (a).

§ 58-51-80. Group accident and health insurance defined.

(a) Any policy or contract of insurance against death or injury resulting from accident or from accidental means which covers more than one person except blanket accident policies as defined in G.S. 58-51-75, shall be deemed a group accident insurance policy. Any policy or contract which insures against disablement, disease or sickness of the insured (excluding disablement which results from accident or from accidental means) and which covers more than one person, except blanket health insurance policies as defined in G.S. 58-51-75, shall be deemed a group health insurance policy or contract. Any policy or contract of insurance which combines the coverage of group accident insurance and of group health insurance shall be deemed a group accident and health insurance policy. No policy or contract of group accident, group health or group accident and health insurance, and no certificates thereunder, shall be delivered or issued for delivery in this State unless it conforms to the requirements of subsection (b).

(b) No policy or contract of group accident, group health or group accident and health insurance shall be delivered or issued for delivery in this State unless the group of persons thereby insured conforms to the requirements of the following subdivisions:

(1) Under a policy issued to an employer, principal, or to the trustee of a fund established by an employer or two or more employers in the same industry or kind of business, or by a principal or two or more principals in the same industry or kind of business, which employer, principal, or trustee shall be deemed the policyholder, covering, except as hereinafter provided, only employees, or agents, of any class or classes thereof determined by conditions pertaining to employment, or agency, for amounts of insurance based upon some plan which will preclude individual selection. The premium may be paid by the employer, by the employer and the employees jointly, or by the employee; and where the relationship of principal and agent exists, the premium may be paid by the principal, by the principal and agents,

jointly, or by the agents. If the premium is paid by the employer and the employees jointly, or by the principal and agents jointly, or by the employees, or by the agents, the group shall be structured on an actuarially sound basis.

(1a) Under a policy issued to an association or to a trust or to the trustee or trustees of a fund established, created, or maintained for the benefit of members of one or more associations. The association or associations shall have at the outset a minimum of 500 persons and shall have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have been in active existence for at least five years; and shall have a constitution and bylaws that provide that (i) the association or associations hold regular meetings not less than annually to further purposes of the members; (ii) except for credit unions, the association or associations collect dues or solicit contributions from members; and (iii) the members, other than associate members, have voting privileges and representation on the governing board and committees. The policy is subject to the following requirements:

a. The policy may insure members of the association or associations, employees of the association or associations, or employees of members, or one or more of the preceding or all of any class or classes for the benefit of persons other than the employee's employer.

b. The premium for the policy shall be paid from funds contributed by the association or associations, or by employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the association, associations, or employer members.

c. Repealed by Session Laws 1997-259, s. 8, effective July 1, 1997.

(2), (3) Repealed by Session Laws 1997-259, s. 8, effective July 1, 1997.

(c) The term "employees" as used in this section shall be deemed to include, for the purposes of insurance hereunder, employees of a single employer, the officers, managers, and employees of the employer and of subsidiary or affiliated corporations of a corporation employer, and the individual proprietors, partners, and employees of individuals and firms of which the business is controlled by the insured employer through stock ownership, contract or otherwise. Employees shall be added to the group coverage no later than 90 days after their first day of employment. Employment shall be considered continuous and not be considered broken except for unexcused absences from work for reasons other than illness or injury. The term "employee" is defined as a nonseasonal person who works on a full-time basis, with a normal work week of 30 or more hours and who is otherwise eligible for coverage, but does not include a person who works on a part-time, temporary, or substitute basis. The term "employer" as used herein may be deemed to include the State of North Carolina, any county, municipality or corporation, or the proper officers, as such, of any unincorporated municipality or any department or subdivision of the State, county, such corporation, or municipality determined by conditions pertaining to the employment.

(d) The term "agents" as used in this section shall be deemed to include, for the purposes of insurance hereunder, agents of a single principal who are under contract to devote all, or substantially all, of their time in rendering personal services for such principal, for a commission or other fixed or ascertainable compensation.

(e) The benefits payable under any policy or contract of group accident, group health and group accident and health insurance shall be payable to the employees, or agents, or to some beneficiary or beneficiaries designated by the employee or agent, other than the employer or principal, but if there is no designated beneficiary as to all or any part of the insurance at the death of the employee or agent, then the amount of insurance payable for which there is no designated beneficiary shall be payable to the estate of the employee or agent, except that the insurer may in such case, at its option, pay such insurance to any one or more of the following surviving relatives of the employee or agent: wife, husband, mother, father, child, or children, brothers or sisters; and except that payment of benefits for expenses incurred on account of hospitalization or medical or surgical aid, as provided in subsection (f), may be made by the insurer to the hospital or other person or persons furnishing such aid. Payment so made shall discharge the insurer's obligation with respect to the amount of insurance so paid.

(f) Any policy or contract of group accident, group health or group accident and health insurance may include provisions for the payment by the insurer of benefits to the employee or agent of the insured group, on account of hospitalization or medical or surgical aid for himself, his spouse, his child or children, or other persons chiefly dependent upon him for support and maintenance.

(g) Any policy or contract of group accident, group health or group accident and health insurance may provide for readjustment of the rate of premium based on the experience thereunder at the end of the first year, or at any time during any subsequent year based upon at least 12 months of experience: Provided that any such readjustment after the first year shall not be made any more frequently than once every six months. Any rate adjustment must be preceded by a 45-day notice to the contract holder before the effective date of any rate increase or any policy benefit revision. A notice of nonrenewal shall be given to the contract holder 45 days prior to termination. Any refund under any plan for readjustment of the rate of premium based on the experience under group policies and any dividend paid under the policies may be used to reduce the employer's or principal's contribution to group insurance for the employees of the employer, or the agents of the principal, and the excess over the contribution by the employer, or principal, shall be applied by the employer, or principal, for the sole benefit of the employees or agents.

(h) Nothing contained in this section applies to any contract issued by any corporation defined in Article 65 of this Chapter. (1945, c. 385; 1947, c. 721; 1951, c. 282; 1953, c. 1095, ss. 6, 7; 1987, c. 752, s. 19; 1989, c. 485, s. 41; c. 775, ss. 1, 2; 1991, c. 644, s. 11; 1993, c. 408, ss. 3, 3.1; c. 409, s. 14; 1995, c. 507, ss. 23A.1(c), 23A.1(d); 1997-259, ss. 8, 9.)

Editor's Note. —

Session Laws 1995, c. 507, s. 1.1, provides that this act shall be known and cited as the Expansion and Capital Improvements Appropriations Act of 1995.

Session Laws 1995, c. 507, s. 28.12 is a severability clause.

Session Laws 1997-259, s. 25, provides: "Sections 1 through 18 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after July 1, 1997. Sections 19, 20, 21, 22, and 23 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after January 1, 1998. For the purposes of this act, renewal of a contract is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the contract."

Effect of Amendments. — Session Laws 1997-259, ss. 8 and 9, effective July 1, 1997, substituted "members, other than associate members" for "members" following "and (iii) the" in subdivision (b)(1a); deleted subdivision (b)(1a)c., concerning policies oon which no part of the premium was derived from funds contributed by the covered persons, subdivision (b)(2), concerning evidence of individual insurability, and subdivision (b)(3), concerning preexisting conditions; and deleted the last section of subsection (h), which read "Subdivision (b)(3) of this section applies to MEWAs, as defined in G.S. 58-49-30(a)." For applicability, see Editor's note.

§ 58-51-115. Coordination of benefits with Medicaid.

(a) As used in this section and in G.S. 58-51-120 and G.S. 58-51-125:

(1) "Health benefit plan" means any accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement. "Health benefit plan" does not mean a Medicare supplement policy as defined in G.S. 58-54-1(5).

(2) "Health insurer" means any health insurance company subject to Articles 1 through 63 of this Chapter, including a multiple employee welfare arrangement, and any corporation subject to Articles 65 and 67 of this Chapter; and means a group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974.

(b) No health insurer shall take into account that an individual is eligible for or is provided medical assistance in this or any other state under 42 U.S.C. § 1396a (section 1902 of the Social Security Act) in insuring that individual or making payments under its health benefit plan for benefits to that individual or on that individual's behalf. (1993 (Reg. Sess., 1994), c. 644, s. 1; 1995, c. 193, s. 43.)

Editor's Note. —
Session Laws 1995, c. 193, s. 67 contains a severability clause.

OPINIONS OF ATTORNEY GENERAL

Medical Child Support Provisions. — The medical child support enforcement provisions of House Bill 1563, 1993 (Reg. Sess. 1994) N.C. Session Laws Ch. 644, are inapplicable to the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan and the governmental entities whose employees and retirees, along with their dependents, are eligible for coverage under the Plan or its HMO option. Medical child support orders nonetheless may be enforced directly against State employees and retirees who fail to enroll, or maintain coverage for, their eligible dependent children under the State Health Plan in accordance with the provisions of §§ 50-13.4(f), 50-13.9 and 50-13.11. See opinion of Attorney General to Patricia Crawford, Associate General Counsel, University of North Carolina at Chapel Hill, — N.C.A.G. — (August 10, 1995).

§ 58-51-120. Coverage of children.

(a) No health insurer shall deny enrollment of a child under the health benefit plan of the child's parent on any of the following grounds:

(1) The child was born out of wedlock.

(2) The child is not claimed as a dependent on the parent's federal income tax return.

(3) The child does not reside with the parent or in the insurer's service area.

(b) If a parent is required by a court or administrative order to provide health benefit plan coverage for a child, and the parent is eligible for family health benefit plan coverage through a health insurer, the health insurer:

(1) Must allow the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions.

(2) Must enroll the child under family coverage upon application of the child's other parent or the Department of Health and Human Services in connection with its administration of the Medical Assistance or Child Support Enforcement Program if the parent is enrolled but fails to make application to obtain coverage for the child.

(3) May not disenroll or eliminate coverage of the child unless the health insurer is provided satisfactory written evidence that:

a. The court or administrative order is no longer in effect; or

b. The child is or will be enrolled in comparable health benefit plan coverage through another health insurer, which coverage will take effect not later than the effective date of disenrollment.

(c) If a child has health benefit plan coverage through the health insurer of a noncustodial parent, that health insurer shall do all of the following:

(1) Provide such information to the custodial parent as may be necessary for the child to obtain benefits through that coverage.

(2) Permit the custodial parent (or the health care provider, with the custodial parent's approval) to submit claims for covered services without the approval of the noncustodial parent.

(3) Make payments on claims submitted in accordance with subdivision (2) of this subsection directly to the custodial parent, the provider, or the Department of Health and Human Services.

(d) No health insurer may impose requirements on any State agency that has been assigned the rights of an individual eligible for medical assistance under Medicaid and covered for health benefits from the insurer that are different from requirements applicable to an agent or assignee of any other individual so covered. (1993 (Reg. Sess., 1994), c. 644, s. 1; 1997-443, s. 11A.118(a).)

Editor's Note. — Session Laws 1997-443, s. 1.1, provides: "This act shall be known as 'The Current Operations and Capital Improvements Appropriations Act of 1997'".

Session Laws 1997-443, s. 35.4, is a severability clause.

Effect of Amendments. — The 1997 amendment, effective August 28, 1997, substituted "Health and Human Services" for "Human Resources."

ARTICLE 53.

Group Health Insurance Continuation and Conversion Privileges.

Part 1. Continuation.

§ 58-53-1. Definitions.

As used in this Article, the following terms have the meanings specified:

(1) "Group policy" means a group accident and health insurance policy issued by an insurance company and a group contract issued by a service corporation or health maintenance organization or similar corporation or organization.

(2) "Individual policy" or "converted policy" means an individual health insurance policy issued by an insurance company or an individual contract issued by a service corporation or health maintenance organization or similar corporation or organization.

(3) "Insurance" and "insured" refer to coverage under a group policy, individual policy or converted policy on a premium-paying basis, and do not include coverage provided by reason of a disability extension.

(4) "Insurer" means the entity issuing a group policy or an individual or converted policy.

(5) "Medicare" means Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended or superseded.

(5a) "Member" or "employee" includes an insured spouse or dependent of a member or of an employee.

(6) "Premium" includes any premium or other consideration payable for coverage under a group or individual policy.

(7) "Reasonable and customary" means the most frequently used level of charge made for the supplies or for a specific service in the geographic subarea in which such supplies or services are received, of like kind or by physicians, or other practitioners, with similar qualifications. (1981, c. 706, s. 1; 1983, c. 142, s. 1; 1997-259, s. 10.)

Editor's Note. — Session Laws 1997-259, s. 25, provides: "Sections 1 through 18 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after July 1, 1997. Sections 19, 20, 21, 22, and 23 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after January 1, 1998. For the purposes of this act, renewal of a contract is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the contract."

Effect of Amendments. — The 1997 amendment, effective July 1, 1997, in subdivision (1) deleted "health" following "issued by a"; in subdivision (2) substituted "contract issued by a" for "health services issued by a health" following "or an individual"; and added subdivision (5a). For applicability, see Editor's note.

§ 58-53-5. Continuation of group hospital, surgical, and major medical coverage after termination of employment or membership.

A group policy delivered or issued for delivery in this State that insures employees or members for hospital, surgical or major medical insurance on an expense incurred or service basis under this Chapter, other than for specific diseases or for accidental injuries only, shall provide that employees or members whose coverage under the group policy would otherwise terminate because of termination of active employment or membership, or termination of membership in the eligible class or classes under the policy, shall be entitled to continue their hospital, surgical, and medical insurance under that group policy, for themselves and their eligible spouses and dependents with respect to whom they were insured on the date of termination, subject to all of the group policy's terms and conditions and to the conditions specified in this Part. Provided, the terms and conditions set forth in this Part are intended as minimum requirements and shall not be construed to impose additional or different requirements upon those group hospital, surgical, or major medical plans that provide continuation benefits equal to or better than those required in this Part. (1981, c. 706, s. 1; 1997-259, s. 11.)

Editor's Note. — Session Laws 1997-259, s. 25, provides: "Sections 1 through 18 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after July 1, 1997. Sections 19, 20, 21, 22, and 23 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after January 1, 1998. For the purposes of this act, renewal of a contract is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the contract."

Effect of Amendments. — The 1997 amendment, effective July 1, 1997, substituted "that insures employees or members" for "which insures employees or members, other than the members and their dependents, if they have elected to include them, whose eligibility under the group policy does not extend to any employee(s) the insured may have" following "in this State", deleted "Articles 1 through 67 of" following "service basis under", deleted "insurance for these types of" preceding "coverage under the group", inserted "spouses and" following "and their eligible", deleted "applicable to those forms of insurance" following "terms and conditions", and deleted "already in force, or hereafter placed into effect" following "major medical plans". For applicability, see Editor's note.

§ 58-53-35. Termination of continuation.

(a) Continuation of insurance under the group policy for any person shall terminate on the earliest of the following dates:

(1) The date 18 months after the date the employee's or member's insurance under the policy would otherwise have terminated because of termination of employment or members;

(2) The date ending the period for which the employee or member last makes his required contribution, if he discontinues his contributions;

(3) The date the employee or member becomes or is eligible to become covered for similar benefits under any arrangement of coverage for individuals in a group, whether insured or uninsured;

(4) The date on which the group policy is terminated or, in the case of a multiple employer plan, the date his employer terminates participation under the group master policy. When this occurs the employee or member shall have the privilege described in G.S. 58-53-45 if the date of termination precedes that on which his actual continuation of insurance under that policy would have terminated. The insurer that insured the group before the date of termination shall make a converted policy available to the employee or member.

(b) Notwithstanding subdivision (a)(4) of this section, if the employer replaces the group policy with another group policy, the employee is entitled to continue under the successor group policy for any unexpired period of continuation to which the employee is entitled. (1981, c. 706, s. 1; 1983, c. 142, s. 2; 1993, c. 529, s. 3.8; 1997-259, s. 12.)

Editor's Note. —

Session Laws 1997-259, s. 25, provides: "Sections 1 through 18 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after July 1, 1997. Sections 19, 20, 21, 22, and 23 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after January 1, 1998. For the purposes of this act, renewal of a contract is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the contract."

Effect of Amendments. — The 1997 amendment, effective July 1, 1997, in subdivision (a)(1) substituted "18 months" for "one year" preceding "after the date"; and in subdivision (a)(4) substituted "before" for "prior to" preceding "the date of". For applicability, see Editor's note.

Part 2. Conversion.

§ 58-53-50. Restrictions.

A converted policy shall not be available to an employee or member if termination of his insurance under the group policy occurred because:

(1) Of termination of employment or membership and either he was not entitled to continuation of group coverage under Part 1 of this Article or failed to elect such continuation;

(2) He failed to make timely payment of any required contribution for the cost of continuation of insurance;

(3) He had not been continuously covered under the group policy or for similar benefits under any other group policy that it replaced during the period of three consecutive months immediately prior to termination of active employment ending with such termination;

(4) The group policy terminated or an employer's participation terminated, and the insurance is replaced by similar coverage under another group policy within 31 days of date of termination; or

(5) He failed to continue his insurance for the entire maximum period of 18 months following termination of active employ-

ment as provided for in Part 1 of this Article, unless that failure to continue was because of change of insurer by the employer and the change of insurer was consummated during the one year continuation period. In that event the employee or member shall be entitled to be issued a converted policy by the insurer that provided the group policy to the employer before the change of insurer. (1981, c. 706, s. 1; 1983, c. 142, s. 3; 1993 (Reg. Sess., 1994), c. 569, s. 9; 1997-259, s. 13.)

Editor's Note. — Session Laws 1997-259, s. 25, provides: "Sections 1 through 18 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after July 1, 1997. Sections 19, 20, 21, 22, and 23 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after January 1, 1998. For the purposes of this act, renewal of a contract is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the contract."

Effect of Amendments. — The 1997 amendment, effective July 1, 1997, substituted "18 months" for "one year" following "maximum period of" in subdivision (5). For applicability, see Editor's note.

§ 58-53-55. Time limit.

In order to be eligible for conversion, written application and the first premium payment for the converted policy must be made to the insurer not later than 31 days after the date of termination of insurance provided under Part 1 of this Article. The effective date of the converted policy shall be the day following the later of:

(1) The termination of insurance under the group policy when it is not replaced by one providing similar coverage within 31 days of the termination date of the immediately prior group plan; or

(2) The termination of the period of continued coverage under the group policy or policies. (1981, c. 706, s. 1; 1993 (Reg. Sess., 1994), c. 569, s. 10; 1997-259, s. 14.)

Editor's Note. — Session Laws 1997-259, s. 25, provides: "Sections 1 through 18 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after July 1, 1997. Sections 19, 20, 21, 22, and 23 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after January 1, 1998. For the purposes of this act, renewal of a contract is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the contract."

Effect of Amendments. — The 1997 amendment, effective July 1, 1997, substituted "period" for "one year" preceding "of continued coverage" in subdivision (2). For applicability, see Editor's note.

§ 58-53-60. Premium.

(a) The premium for the converted policy or group conversion trust certificate shall be determined in accordance with the insurer's table of premium rates applicable to the age and class of risk to be covered under that policy and to the type and amount of insurance provided.

(b) All insurers licensed to do business in this State, who issue conversion policies or group conversion trust certificates under this Part, have the right to increase that element of the premium that applies to hospital room and board benefit increases provided for in G.S. 58-53-95(5) by an amount proportionate to the increase promulgated by the Commissioner. Such premium increases shall be filed with the Commissioner.

(c) All premium rates and adjustments to premium rates for converted policies or group conversion trust certificates shall be reasonable and must be filed with and approved by the Commissioner prior to use. A premium rate shall be deemed to be reasonable if the insurer demonstrates that the premium charged is expected to produce an incurred loss ratio to earned premiums of not less than sixty percent (60%) for all policies or group conversion trust certificates providing similar benefits offered and issued by the insurer. If an insurer experiences an incurred loss ratio of greater than eighty percent (80%) for all such policies, it shall be deemed reasonable for that insurer to increase premium rates to a level that will produce a prospective incurred loss ratio of no greater than eighty percent (80%), and the insurer shall file such new rates with the Commissioner not more often than once a year. (1981, c. 706, s. 1; 1983, c. 669; 1995, c. 517, s. 30.)

Editor's Note. — Session Laws 1995, c. 517, s. 41, contains a severability clause.

ARTICLE 55.

Long-Term Care Insurance.

§ 58-55-31. Additional requirements.

(a) No policy shall be used in this State unless it provides for an offer of nonforfeiture, which shall not be less than an offer of reduced paid-up insurance benefits, extended term insurance benefits, or a shortened benefit period. No policy shall pay a cash surrender value unless the dividends or refunds are applied as a reduction of future premiums or an increase in future benefits.

(b) The Commissioner shall adopt rules to provide for annual reports by insurers of the number of claims denied, number of rescissions, and the percentage of sales involving the replacement of policies.

(c) No policy shall be used in this State unless the insurer has developed a financial or personal asset suitability test to determine whether or not issuing long-term care insurance to an applicant is appropriate. For purposes of this section:

(1) All insurers except those issuing life insurance that accelerates the death benefit for long-term care shall use the financial or suitability form and format standards as developed and adopted by the NAIC. A personal long-term care worksheet and disclosure notice of issues an applicant should know before buying long-term care insurance shall be completed and provided before an application is taken.

(2) Each applicant that does not meet the recommended financial or personal asset suitability test criteria shall receive a letter of notification and shall be given an option to waive the results of the financial suitability test and proceed with the purchase of the policy.

(d) The Commissioner shall adopt standards to handle consumer complaints about noncompliance with State requirements. (1997-259, s. 15.)

Editor's Note. — Session Laws 1997-259, s. 15, made this section effective July 1, 1997.

Session Laws 1997-259, s. 25, provides: "Sections 1 through 18 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after July 1, 1997. Sections 19, 20, 21, 22, and 23 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after January 1, 1998. For the purposes of this act, renewal of a contract is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the contract."

§ 58-55-35. Facilities, services, and conditions defined.

(a) Whenever long-term care insurance provides coverage for the facilities, services, or physical or mental conditions listed below, unless otherwise defined in the policy and certificate, and approved by the Commissioner, such facilities, services, or conditions are defined as follows:

(1) "Adult care home" shall be defined in accordance with the terms of G.S. 131D-2(a)(3).

(1a) "Adult day care program" shall be defined in accordance with the provisions of G.S. 131D-6(b).

(2) "Chore" services include the performance of tasks incidental to activities of daily living that do not require the services of a trained homemaker or other specialist. Such services are provided to enable individuals to remain in their own homes and may include such services as: assistance in meeting basic care needs such as meal preparation; shopping for food and other necessities; running necessary errands; providing transportation to essential service facilities; care and cleaning of the house, grounds, clothing, and linens.

(3) "Combination home" shall be defined in accordance with the terms of G.S. 131E-101(1).

(4) Repealed by Session Laws 1995, c. 535, s. 3, effective October 1, 1995.

(5) "Family care home" shall be defined in accordance with the terms of G.S. 131D-2(a)(5).

(6) "Group home for developmentally disabled adults" shall be defined in accordance with the terms of G.S. 131D-2(a)(6).

(7) Repealed by Session Laws 1995, c. 535, s. 3, effective October 1, 1995.

(8) "Home health services" shall be defined in accordance with the terms of G.S. 131E-136(3).

(9) "Homemaker services" means supportive services provided by qualified para-professionals who are trained, equipped, assigned, and supervised by professionals within the agency to help maintain, strengthen, and safeguard the care of the elderly in their own homes. These standards must, at a minimum, meet standards established by the North Carolina Division of Social Services and may include: Providing assistance in management of household budgets; planning nutritious meals; purchasing and preparing

foods; housekeeping duties; consumer education; and basic personal and health care.

(10) "Hospice" shall be defined in accordance with the terms of G.S. 131E-176(13a).

(11) "Intermediate care facility" shall be defined in accordance with the terms of G.S. 131E-176(14b).

(12) "Nursing home" shall be defined in accordance with the terms of G.S. 131E-101(6).

(13) "Respite care, institutional" means provision of temporary support to the primary caregiver of the aged, disabled, or handicapped individual by taking over the tasks of that person for a limited period of time. The insured receives care for the respite period in an institutional setting, such as a nursing home, family care home, rest home, or other appropriate setting.

(14) "Respite care, non-institutional" means provision of temporary support to the primary caregiver of the aged, disabled, or handicapped individual by taking over the tasks of that person for a limited period of time in the home of the insured or other appropriate community location.

(15) "Skilled Nursing Facility" shall be defined in accordance with the terms of G.S. 131E-176(23).

(b) Whenever long-term care insurance provides coverage for organic brain disorder syndrome, progressive dementing illness, or primary degenerative dementia, such phrases shall be interpreted to include Alzheimer's Disease. Clinical diagnosis of "organic brain disorder syndrome", "progressive dementing illness", and "primary degenerative dementia" must be accepted as evidence that such conditions exist in an insured when a pathological diagnosis cannot be made; provided that such medical evidence substantially documents the diagnosis of the condition and the insured received treatment for such condition.

(c) All long-term care insurance policies must be filed with and approved by the Commissioner before they can be used in this State and are subject to the provisions of Article 38 of this Chapter. (1987, c. 331, s. 1; 1989, c. 207, ss. 5, 6; 1995, c. 535, s. 3.)

Editor's Note. — Section 131D-2(a)(3), referred to in subdivision (a)(1), was repealed by Session Laws 1995, c. 535, s. 8.

The subdivision (a)(1a) designation and the order of subdivisions in subsection (a) were assigned by the Revisor of Statues.

The reference in subdivision (a)(15) above to § 131E-176(23) should probably now be § 131E-176(17a).

Session Laws 1995, c. 535, which amended this section, in s. 37 provides: "Rules adopted by the Department of Human Resources, the Medical Care Commission, and the Social Services Commission regulating domiciliary care homes prior to the effective date of this act remain in effect for adult care homes until amended or repealed."

ARTICLE 57.

Regulation of Credit Insurance.

§ 58-57-5. Definitions.

As used in this Article, unless the context requires otherwise, the following words or terms shall have the meanings herein ascribed to them, respectively:

(1) Repealed by Session Laws 1991, c. 720, s. 6.
(2) "Credit accident and health insurance" means insurance on a debtor to provide indemnity for payments becoming due on a specific loan or other credit transaction as defined in G.S. 58-51-100, with or without insurance against death by accident.
(2a) "Credit insurance agent" means an agent of an insurance company licensed in this State who is authorized to solicit, negotiate or effect credit life insurance, credit accident and health insurance, credit unemployment insurance, credit property insurance, or any of them, but only to the extent as is authorized and limited in this Article.
(3) "Credit life insurance" means insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transaction as defined in G.S. 58-58-10.
(4) Recodified as G.S. § 58-57-5(2a) (See Note.)
(4a) "Credit transaction" means any transaction by the terms of which the repayment of money loaned or loan commitment made, or payment for goods, services, or properties sold or leased, is to be made at a future date or dates.
(4b) "Credit unemployment insurance" means insurance on a debtor in connection with a specified loan or other credit transaction to provide payment to a creditor of the debtor for the installment payments or other periodic payment becoming due while the debtor is involuntarily unemployed as defined in the policy.
(5) "Creditor" means any lender of money or vendor or lessor of goods, services, property, rights or privileges, including any person that directly or indirectly provides credit in connection with any such sale or lease, for which payment is arranged through a credit-related transaction; or any successor to the right, title or interest of any such lender, vendor, lessor, or person extending credit, and an affiliate, associate, or subsidiary of any of them, or any director, officer, or employee of any of them or any other person in any way associated with any of them.
(6) "Debtor" means a borrower of money or a purchaser or lessee of goods, services, property, rights or privileges for which payment is arranged through a credit transaction.
(7) "Indebtedness" means the total amount payable for the term of the loan by debtor to creditor in connection with a loan or other credit transaction, including principal, interest, allowable charges, and any premiums authorized hereunder.
(7a) "Joint accident and health coverage" means credit accident and health insurance covering two or more debtors; provided that only one monthly benefit, as defined in G.S. 58-57-15(b), shall be payable each month on a specific indebtedness regardless of the number of debtors insured.
(8) "Joint life coverage" means credit life insurance covering two or more lives, the entire amount of insurance being payable upon the death of the first insured debtor to die.
(9) "Lease" means a contract whereby the lessee of a "motor vehicle," as defined in G.S. 20-4.01(23), contracts to pay as compensation for use a sum substantially equivalent to or in excess of the aggregate value of the property, but not exceeding the term of years in G.S. 58-57-1.

(10) "Open-end credit" means credit extended by a creditor under an agreement in which:
  a. The creditor reasonably contemplates repeated transactions;
  b. The creditor imposes a finance charge from time to time on an outstanding unpaid balance; and
  c. The amount of credit that may be extended to the debtor during the term of the agreement (up to any limit set by the creditor) is generally made available to the extent that any outstanding balance is repaid.

"Open-end credit" includes credit card balances.

(11) "Truncated coverage" means a credit insurance benefit with a term of insurance coverage that is less than the term of the credit transaction. (1975, c. 660, s. 1; 1987, c. 826, ss. 2, 3; 1991, c. 720, s. 6; 1993, c. 226, s. 2; 1995, c. 193, s. 45; c. 208, s. 1.)

Editor's Note. — Session Laws 1995, c. 193, s. 67 contains a severability clause.

Effect of Amendments. — Session Laws 1995, c. 208, s. 1, which amended this section was effective June 8, 1995, and applicable to all actions filed on or after that date.

ARTICLE 58.

General Regulations of Business—Life Insurance.

§ 58-58-22. Individual policy standard provisions.

No policy of individual life insurance shall be delivered in this State unless it contains in substance the following provisions, or provisions that in the Commissioner's opinion are more favorable to the person insured:

(1) Grace period. — A provision that the insured is entitled to a grace period of 31 days for the payment of any premium due except the first, during which grace period the death benefit coverage shall continue in force. The policy may provide that if a claim arises under the policy during the grace period, the amount of any premium due or overdue may be deducted from any amount payable under the policy in settlement.

(2) Incontestability. — A provision that the validity of the policy shall not be contested, except for nonpayment of premium, once it has been in force for two years after its date of issue; and that no statement made by any person insured under the policy about that person's insurability shall be used during the person's lifetime to contest the validity of the policy after the insurance has been in force for two years.

(3) Misstatement of age or gender. — A provision specifying an equitable adjustment of premiums or benefits, or both, to be made if the age or gender of the person insured has been misstated; the provision to contain a clear statement of the method of adjustment to be used.

(4) Suicide. — A provision that may not limit payment of benefits for a period more than two years after the date of issue of the policy because of suicide and that provides for at least the return of premiums paid on the policy if there is suicide during the two-year period.

(5) Reinstatement. — A provision that, unless the policy has been surrendered for its cash surrender value, or its cash surrender value has been exhausted, the policy will be reinstated at any time within five years after the date of premium default upon written application therefor, the production of evidence of insurability satisfactory to the insurer, the payment of all overdue premiums, and the payment of reinstatement of any other indebtedness to the insurer upon the policy, all with interest at the rate specified. (1995, c. 517, s. 31(a).)

Editor's Note. — Session Laws 1995, c. 517, s. 42, made this section effective October 1, 1995.

Session Laws 1995, c. 517, s. 41, contains a severability clause.

§ 58-58-23. Standard provisions for annuity and pure endowment contracts.

No annuity or pure endowment contract, except a reversionary or survivorship annuity and except a group annuity contract, shall be delivered or issued for delivery in this State unless it contains in substance the following provisions or provisions that in the opinion of the Commissioner are more favorable to the holders of the contracts:

(1) Grace period. — A provision for a grace period of not less than 31 days within which any stipulated payment to the insurer falling due after the first payment may be made. During the grace period, the contract shall continue in full force. If a claim arises under the contract because of death before the expiration of the grace period and before the overdue payment to the insurer is made, the amount of the payments, with interest on any overdue payments, may be deducted from any amount payable under the contract.

(2) Incontestability. — If any statements are required as a condition of issue, there shall be a provision that the contract shall be incontestable during the lifetime of the person or of each of the persons as to whom the statements are required after it has been in force for a period of two years after its date of issue, except for nonpayment of stipulated payments to the insurer.

(3) Misstatements of age or gender. — A provision that if the age or gender of any person upon whose life the contract is made has been misstated, the amount payable or benefits accruing under the contract shall be such as the stipulated payment or payments to the insurer would have been according to the correct age or gender; and if the insurer makes an overpayment because of the misstatement, that amount with interest at the rate specified in the contract may be charged against any current or subsequent payment by the insurer under the contract.

(4) Reinstatement. — A provision that the contract may be reinstated at any time within one year after a default in making stipulated payments to the insurer, unless the cash surrender value has been paid; but all overdue stipulated payments and any indebtedness to the insurer on the contract shall be paid or reinstated with interest at a rate

specified in the contract. When applicable, the insurer may also require evidence of insurability satisfactory to the insurer. (1995, c. 517, s. 31(a).)

Editor's Note. — Session Laws 1995, c. 517, s. 42, made this section effective October 1, 1995.

Session Laws 1995, c. 517, s. 41, contains a severability clause.

§ 58-58-42. Viatical settlements.

(a) Definitions. — As used in this section:

(1) "Broker" means a person who, for consideration and on behalf of another, offers or advertises the availability of viatical settlements, introduces viators to providers, or offers or attempts to negotiate viatical settlement contracts between a viator and one or more providers; it does not mean an attorney, accountant, or financial planner retained to represent a viator and whose compensation is not paid by a provider.

(2) "Policy" means an individual life insurance policy or a certificate under a group life insurance policy.

(3) "Provider" means a person who enters into a viatical settlement contract with a viator. "Provider" does not mean:

a. A licensed lending institution that takes an assignment of a policy as collateral for a loan.

b. The issuer of a policy providing accelerated benefits under 11 NCAC 12.1200.

c. A natural person who enters into no more than one agreement in a calendar year for the transfer of a policy for any value less than the expected death benefit.

(4) "Viatical settlement contract" or "contract" means a written agreement entered into between a provider and a viator that establishes the terms under which the provider will pay consideration that is less than the expected death benefit of the viator's policy in return for the viator's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of the policy to the provider.

(5) "Viator" means the owner or holder of a policy who has a catastrophic or life-threatening illness or condition and who enters into a viatical settlement contract.

(b) Registration. — No person may act as a provider or enter into or solicit a contract without first registering with the Commissioner. The applicant shall register on a form prescribed by the Commissioner. The Commissioner may require the applicant to disclose fully the identity of all stockholders, partners, officers, and employees. The Commissioner may refuse registration of any partnership, corporation, or other business entity if not satisfied that any officer, employee, stockholder, or partner who may materially influence the applicant's conduct meets the standards of this section. Registration of a partnership, corporation, or other business entity authorizes all members, officers, and designated employees to act as providers under the registration; all of those persons must be named in the application and any supplements to the application. Before any registration is complete, the Commissioner shall investigate each applicant and may register the applicant if the Commissioner finds that the applicant:

(1) Has provided a detailed plan of operation.
(2) Is competent and trustworthy and intends to act in good faith in the capacity involved by the license applied for.
(3) Has a good business reputation and has had experience, training, or education so as to be qualified in the business for which the license is applied.
(4) If a corporation, is incorporated under the laws of this State or is a foreign corporation authorized to transact business in this State.

No registration is complete for any nonresident applicant unless a written designation of an agent for service of process is filed and maintained with the Commissioner or the applicant has filed with the Commissioner the applicant's written irrevocable consent that any action against the applicant may be commenced against the applicant by service of process on the Commissioner.

(c) Enforcement. — The Commissioner may issue a cease and desist order upon any provider if the Commissioner finds that:
(1) There was any misrepresentation in the application for registration;
(2) The provider has been guilty of fraudulent or dishonest practices, is subject to a final administrative action, or is otherwise shown to be untrustworthy or incompetent to act as a provider;
(3) The provider demonstrates a pattern of unreasonable payments to policy owners;
(4) The provider has been convicted of a felony or any misdemeanor of which criminal fraud is an element; or
(5) The provider has violated a provision of this section.

(d) Approval of Contracts. — No provider may use any viatical settlement contract in this State unless it has been filed with and approved by the Commissioner. Any contract form filed with the Commissioner is deemed to be approved if it has not been disapproved within 90 days after the filing. The Commissioner shall disapprove a contract form if, in the Commissioner's opinion, any provision of the contract is unreasonable, contrary to the public interest, or otherwise misleading or unfair to the policy owner.

(e) Reporting Requirements. — Each provider shall file with the Commissioner on or before March 1 of each year a statement containing the information required by the rules adopted by the Commissioner.

(f) Examination. — The Commissioner may, when the Commissioner deems it to be reasonably necessary to protect the public interest, examine the business and affairs of any provider or applicant for registration. The Commissioner may order any provider or applicant to produce records, books, files, or other information that is necessary to ascertain whether or not the provider or applicant is acting or has acted in violation of this section or otherwise contrary to the public interest. The provider or applicant shall pay the expenses incurred in conducting an examination. Names and individual identification data for all viators are confidential and shall not be disclosed by the Commissioner. The provider shall maintain records of all transactions of contracts and make the records available to the Commissioner for inspection during reasonable business hours.

(g) Disclosure. — A provider shall disclose the following information to the viator no later than the date the contract is signed by all parties:

(1) Options other than the contract for a person with a catastrophic or life-threatening illness, including, but not limited to, accelerated benefits offered by the issuer of the policy.

(2) The fact that some or all of the contract consideration may be taxable, and that assistance should be sought from a personal tax advisor.

(3) The fact that the contract consideration could be subject to the claims of creditors.

(4) The fact that receipt of the contract consideration may adversely affect the viator's eligibility for Medicaid or other government benefits or entitlements; and that advice should be obtained from the appropriate government agencies.

(5) The viator's right to rescind a contract within 30 days after the date it is executed by all parties or within 15 days after the receipt of the contract consideration by the viator, whichever is less, as provided in subsection (h) of this section.

(6) The date by which the contract consideration will be available to the viator and the source of the consideration.

(h) General Rules. — A provider entering into a contract with a viator shall first obtain:

(1) A written statement from a licensed attending physician that the viator is of sound mind and under no constraint or undue influence.

(2) A witnessed document in which the viator (i) consents to the contract, (ii) acknowledges the catastrophic or life-threatening illness, (iii) represents that the viator has a full and complete understanding of the contract, (iv) represents that the viator has a full and complete understanding of the benefits of the policy, and (v) releases the medical records and acknowledges that the contract has been entered into freely and voluntarily.

All medical information solicited or obtained by any provider is subject to all State laws relating to confidentiality of medical information. All contracts entered into in this State shall contain an unconditional refund provision for at least 30 days after the date of the contract, or 15 days after the receipt of the viatical settlement proceeds, whichever is less.

(i) Contract Consideration. — Immediately upon receipt from the viator of documents to effect the transfer of the policy, the provider shall direct the contract consideration to an escrow or trust account managed by a trustee or escrow agent in a bank approved by the Commissioner, pending acknowledgment of the transfer by the issuer of the policy. The trustee or escrow agent shall transfer the proceeds that are due to the viator immediately upon receipt of acknowledgment of the transfer from the insurer. Failure to tender the contract consideration by the date disclosed to the viator renders the contract null and void.

(j) Authority to Adopt Standards. — The Commissioner may:

(1) Adopt rules to implement this section.

(2) Establish standards for evaluating reasonableness of payments under contracts. This authority includes regulation of discount rates used to determine the amount paid in exchange for assignment, transfer, sale, devise, or bequest of a benefit under a policy.

(3) Establish appropriate registration and other regulatory requirements for brokers.

(4) Require a bond.

(k) Unfair Trade Practices. — A violation of this section is considered an unfair trade practice under Article 63 of this Chapter. (1995, c. 517, s. 31(b).)

Editor's Note. — Session Laws 1995, c. 517, s. 42, made this section effective October 1, 1995.

Session Laws 1995, c. 517, s. 41, contains a severability clause.

§ 58-58-110. Interest payments on death benefits.

(a) Each insurer admitted to transact insurance in this State which, without the written consent of the beneficiary, fails or refuses to pay the death proceeds or death benefits in accordance with the terms of any policy providing a death benefit issued by it in this State within 30 days after receipt of satisfactory proof of loss because of the death, whether accidental or otherwise, of the insured shall pay interest, at a rate not less than the then current rate of interest on death proceeds left on deposit with the insurer computed from the date of the insured's death, on any moneys payable and unpaid after the expiration of the 30-day period. As used in this subsection, the phrase "satisfactory proof of loss because of the death" includes, but is not limited to, a certified copy of the death certificate; or a written statement by the attending physician at the time of death that contains the following information: (i) the name and address of the physician, who must be duly licensed to practice medicine in the United States; (ii) the name of the deceased; (iii) the date, time, and place of the death; and (iv) the immediate cause of the death.

(b) Within the meaning of this section, payment of proceeds or benefits shall be deemed to have been made on the date upon which a check, draft or other valid instrument equivalent to the payment of money was placed in the United States mails in a properly addressed, postpaid envelope, or, if not so posted, on the date of delivery of such instrument to the beneficiary.

(c) This section does not allow an insurer to withhold payment of money payable under any policy providing a death benefit to any beneficiary for a period longer than reasonably necessary to determine whether benefits are payable and to transmit the payment.

(d) This section shall not apply to policies of insurance issued prior to the effective date of this section to the extent that such policies contain specific provisions in conflict with this section. (1977, c. 395, s. 1; 1983, c. 749; 1985, c. 666, s. 45; 1991, c. 644, s. 8; 1995, c. 193, s. 46.)

Editor's Note. — Session Laws 1995, c. 193, s. 67, contains a severability clause.

§ 58-58-125. Minimum premium rates for assessment life insurance companies.

Editor's Note. — Section 143B-472 referred to above has been repealed.

ARTICLE 60.

Regulation of Life Insurance Solicitation.

§ 58-60-35. Disclosure of prearrangement insurance policy provisions.

(a) As used in this section:

(1) "Prearrangement" means any contract, agreement, or mutual understanding, or any series or combination of contracts, agreements or mutual understandings, whether funded by trust deposits or prearrangement insurance policies, or any combination thereof, which has for a purpose the furnishing or performance of specific funeral services, or the furnishing or delivery of specific personal property, merchandise, or services of any nature in connection with the final disposition of a dead human body, to be furnished or delivered at a time determinable by the death of the person whose body is to be disposed of, but does not mean the furnishing of a cemetery lot, crypt, niche, mausoleum, grave marker or monument.

(2) "Prearrangement insurance policy" means a life insurance policy, annuity contract, or other insurance contract, or any series of contracts or agreements in any form or manner, issued on a group or individual basis by an insurance company authorized by law to do business in this State, which, whether by assignment or otherwise, has for its sole purpose the funding of a specific preneed funeral contract or a specific insurance-funded funeral or burial prearrangement, the insured being the person for whose service the funds were paid.

(b) The following information shall be adequately disclosed by the insurance agent or limited representative at the time an application is made, prior to accepting the applicant's initial premium, for a prearrangement insurance policy:

(1) The fact that a prearrangement insurance policy is involved or being used to fund a prearrangement;

(2) The nature of the relationship among the insurance agent or limited representative, the provider of the funeral or cemetery merchandise or services, the administrator, and any other person;

(3) The relationship of the prearrangement insurance policy to the funding of the prearrangement and the nature and existence of any guarantees relating to the prearrangement;

(4) The effect on the prearrangement of (i) any changes in the prearrangement insurance policy, including but not limited to, changes in the assignment, beneficiary designation, or use of the policy proceeds; (ii) any penalties to be incurred by the insured as a result of failure to make premium payments; and (iii) any penalties to be incurred or monies to be received as a result of cancellation or surrender of the prearrangement insurance policy;

(5) All relevant information concerning what occurs and whether any entitlements or obligations arise if there is a

difference between the policy proceeds and the amount actually needed to fund the prearrangement; and

(6) Any penalties or restrictions, including geographic restrictions or the inability of the provider to perform, on the delivery of merchandise, services, or the prearrangement guarantee. (1989, c. 738, s. 1; 1991, c. 644, s. 10; 1995, c. 517, s. 32.)

Editor's Note. — Session Laws 1995, c. 517, s. 41, contains a severability clause.

ARTICLE 62.

Life and Health Insurance Guaranty Association.

§ 58-62-16. Definitions.

As used in this Article:

(1) "Account" means any of the two accounts created under G.S. 58-62-26.

(2) "Association" means the North Carolina Life and Health Insurance Guaranty Association created under G.S. 58-62-26.

(3) "Board" means the board of directors of the Association established under G.S. 58-62-31.

(4) "Contractual obligation" means any obligation under a policy or certificate under a group policy, or part thereof, for which coverage is provided under G.S. 58-62-21.

(5) "Covered policy" means any policy within the scope of this Article under G.S. 58-62-21.

(6) "Delinquent insurer" means an impaired insurer or an insolvent insurer; and "delinquency" means an insurer impairment or insolvency.

(7) "Health insurance" includes hospital or medical service corporation contracts, accident and health insurance, accident insurance, and disability insurance.

(8) "Impaired insurer" means a member insurer that, after the effective date of this Article, is not an insolvent insurer, and (i) is deemed by the Commissioner to be potentially unable to fulfill its contractual obligations or (ii) is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(9) "Insolvent insurer" means a member insurer that, after the effective date of this Article, is placed under an order of liquidation with a finding of insolvency by a court of competent jurisdiction.

(10) "Insurance regulator" means the official or agency of another state that is responsible for the regulation of a foreign insurer.

(11) "Member insurer" means any insurer and any hospital or medical service corporation that is governed by Article 65 of this Chapter and that is licensed or that holds a license to transact in this State any kind of insurance for which coverage is provided under G.S. 58-62-21; and includes any insurer whose license in this State may have been sus-

pended, revoked, not renewed or voluntarily withdrawn, but does not include an entity governed by Article 67 of this Chapter; fraternal order or fraternal benefit society; mandatory State pooling plan; mutual assessment company or any entity that operates on an assessment basis; insurance exchange; or any entity similar to any of the foregoing.

(12) "Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto.

(13) "Person" includes an individual, corporation, company, partnership, association, or aggregation of individuals.

(14) "Plan" means the plan of operation established under G.S. 58-62-46.

(15) "Policy" includes a master group contract and subscriber contract under Article 65 of this Chapter, a contract of insurance and an annuity contract.

(16) "Premiums" means amounts received in any calendar year on covered policies less premiums, considerations, and deposits returned thereon, and less dividends and experience credits thereon. "Premiums" does not include any amounts received for any policies or for the parts of any policies for which coverage is not provided under G.S. 58-62-21(b); except that assessable premium shall not be reduced on account of G.S. 58-62-21(c)(3) relating to interest limitations and G.S. 58-62- 21(d)(2) relating to limitations with respect to any one individual, any one participant, and any one contract holder.

(17) "Resident" means any person who resides in this State when a member insurer is determined to be a delinquent insurer and to whom a contractual obligation is owed. A person may be a resident of only one state, which in the case of a person other than a natural person shall be its principal place of business. "Resident" also means a U.S. citizen residing outside of the United States who owns a covered policy that was purchased from a member insurer while that person resided in this State.

(18) "Unallocated annuity contract" means any annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate. (1991, c. 681, s. 56; 1993, c. 452, s. 60; 1995, c. 177, s. 1.)

§ 58-62-36. Powers and duties of the Association.

(a) If a member insurer is an impaired domestic insurer, the Association may, subject to any conditions imposed by the Association and approved by the Commissioner that do not impair the contractual obligations of the impaired insurer and that are, except in cases of court-ordered conservation or rehabilitation, also approved by the impaired insurer:

(1) Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the policies of the impaired insurer;

(2) Provide such monies, pledges, notes, guarantees, or other means as are proper to carry out subdivision (1) of this

subsection and assure payment of the contractual obligations of the impaired insurer pending action under subdivision (1) of this subsection; or

(3) Lend money to the impaired insurer.

(b) If a member insurer is an impaired insurer, whether domestic, foreign, or alien, and the insurer is not paying claims in a timely manner, then subject to the preconditions specified in subsection (c) of this section, the Association shall, in its discretion, either:

(1) Take any of the actions specified in subsection (a) of this section, subject to the conditions therein; or

(2) Provide substitute benefits in lieu of the contractual obligations of the impaired insurer solely for health claims, periodic annuity benefit payments, death benefits, supplemental benefits, and cash withdrawals for policyowners who petition therefor under claims of emergency or hardship in accordance with standards proposed by the Association and approved by the Commissioner.

(c) The Association is subject to the requirements of subsection (b) of this section only if:

(1) The laws of the impaired insurer's state of domicile provide that until all payments of or on account of the impaired insurer's contractual obligations by all guaranty associations, along with all expenses thereof and interest on all the payments and expenses, have been repaid to the guaranty associations or a plan of repayment by the impaired insurer has been approved by the guaranty associations, the delinquency proceeding shall not be dismissed; neither the impaired insurer nor its assets may be returned to the control of its shareholders or private management; and the impaired insurer may not solicit or accept new business or have any suspended or revoked license restored; and

(2) The impaired insurer is a domestic insurer that has been placed under an order of rehabilitation by a court of competent jurisdiction in this State; or the impaired insurer is a foreign or alien insurer that has been prohibited from soliciting or accepting new business in this State, its license has been suspended or revoked in this State, and a petition for rehabilitation or liquidation has been filed in a court of competent jurisdiction in its state of domicile by that state's insurance regulator.

(d) If a member insurer is an insolvent insurer, the Association shall, in its discretion, either:

(1) Guarantee, assume or reinsure, or cause to be guaranteed, assumed, or reinsured, the policies of the insolvent insurer; or

(2) Assure payment of the contractual obligations of the insolvent insurer; and

(3) Provide such monies, pledges, guarantees, or other means as are reasonably necessary to discharge those duties; or

(4) With respect only to life and health insurance policies, provide benefits and coverages in accordance with subsection (e) of this section.

(e) When proceeding under subdivision (b)(2) or (d)(4) of this section, the Association shall, with respect to only life and health insurance policies:

(1) Assure payment of benefits for premiums identical to the premiums and benefits (except for terms of conversion and

renewability) that would have been payable under the policies of the insolvent insurer, for claims incurred:

a. With respect to group policies, not later than the earlier of the next renewal date under the policies or 45 days, but in no event less than 30 days after the date on which the Association becomes obligated with respect to the policies;

b. With respect to individual policies, not later than the earlier of the next renewal date (if any) under the policies or one year, but in no event less than 30 days from the date on which the Association becomes obligated with respect to the policies;

(2) Make diligent efforts to provide all known insureds or group policyholders with respect to group policies 30 days' notice of the termination of the benefits provided; and

(3) With respect to individual policies, make available to each known insured, or owner if other than the insured, and with respect to an individual formerly insured under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of subsection (f) of this section, if the insured had a right under law or the terminated policy to convert coverage to individual coverage or to continue an individual policy in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provision of the policy or had a right only to make changes in premium by class.

(f) In providing the substitute coverage required under subdivision (e)(3) of this section, the Association may offer either to reissue the terminated coverage or to issue an alternative policy. An alternative or reissued policy shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy. The Association may reinsure any alternative or reissued policy.

(g) Alternative life or health insurance policies adopted by the Association are subject to the Commissioner's approval. The Association may adopt alternative policies of various types for future issuance without regard to any particular delinquency. Alternative policies shall contain at least the minimum statutory provisions required in this State and provide benefits that are not unreasonable in relation to the premium charged. The Association shall set the premium in accordance with a table of rates, which it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but it shall not reflect any changes in the health of the insured after the original policy was last underwritten. Any alternative policy issued by the Association shall provide coverage of a type similar to that of the policy issued by the delinquent insurer, as determined by the Association.

(h) If the Association elects to reissue terminated coverage at a premium rate different from that charged under the terminated life or health insurance policy, the premium shall be set by the Association in accordance with the amount of insurance provided and the age and class of risk, subject to the approval of the Commissioner or by a court of competent jurisdiction.

(i) The Association's obligations with respect to coverage under any life or health insurance policy of the delinquent insurer or under any reissued or alternative policy cease on the date the coverage or policy is replaced by another similar policy by the policyholder, the insured, or the Association.

(j) When proceeding under subdivision (b)(2) of this section or under subsection (c) of this section with respect to any policy carrying guaranteed minimum interest rates, the Association shall assure the payment or crediting of a rate of interest consistent with G.S. 58-62-21(c)(3).

(k) Nonpayment of premiums within 31 days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or substitute coverage terminates the Association's obligations under the policy or coverage under this Article with respect to the policy or coverage, except with respect to any claims incurred or any net cash surrender value that may be due under this Article.

(*l*) Premiums due for coverage after an entry of an order of liquidation of an insolvent insurer belong to and are payable at the direction of the Association; and the Association is liable for unearned premiums owed to policyowners arising after the entry of the order.

(m) The protection provided by this Article does not apply where any similar guaranty protection is provided to residents of this State by the laws of the domiciliary state or jurisdiction of a delinquent foreign or alien insurer.

(n) In carrying out its duties under subsections (b) through (d) of this section, the Association may, subject to approval by the court:

(1) Impose permanent policy liens in connection with any guarantee, assumption, or reinsurance agreement, if the Association finds that the amounts that can be assessed under this Article are less than the amounts needed to assure full and prompt performance of the Association's duties under this Article, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of the permanent policy liens to be in the public interest;

(2) Impose temporary moratoria or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies, in addition to any contractual provisions for deferral of cash or policy loan value.

(o) If the Association fails to act within a reasonable period of time as provided in subdivision (b)(2) of this section and subsections (d) and (e) of this section, the Commissioner has the powers and duties of the Association under this Article with respect to delinquent insurers.

(p) The Association may render assistance and advice to the Commissioner, upon the Commissioner's request concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any delinquent insurer.

(q) The Association has standing to appear before any court in this State with jurisdiction over a delinquent insurer for which the Association is or may become obligated under this Article. This standing extends to all matters germane to the powers and duties of the Association, including, but not limited to, proposals for reinsuring, modifying, or guaranteeing the policies of the delinquent insurer and the determination of the policies and contractual obligations. The Association also has the right to appear or intervene before a court in another state with jurisdiction over a delinquent insurer for which the Association is or may become obligated or with jurisdiction over a third party against whom the Association may have rights through subrogation of the insurer's policyholders.

(r) Any person receiving benefits under this Article is considered to have been assigned the rights under, and any causes of action relating to, the covered policy to the Association to the extent of the benefits received because of this Article, whether the benefits are payments of or on account of contractual obligations, continuation of coverage, or provision of substitute or alternative coverages. The Association may require an assignment to it of such rights and cause of action by any payee, policyowner, beneficiary, insured or annuitant as a condition precedent to the receipt of any right or benefits conferred by this Article upon the person. The subrogation rights of the Association under this subsection have the same priority against the delinquent insurer's assets as that possessed by the person entitled to receive benefits under this Article. In addition to other provisions of this subsection, the Association has all common-law rights of subrogation and any other equitable or legal remedy that would have been available to the delinquent insurer or holder of a policy with respect to the policy.

(s) The Association may:

(1) Enter into contracts that are necessary or proper to carry out the provisions and purposes of this Article;

(2) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under G.S. 58-62-41 and to settle claims or potential claims against it;

(3) Borrow money to effect the purposes of this Article; any notes or other evidence of indebtedness of the Association not in default shall be legal investments for domestic insurers and may be carried as admitted assets;

(4) Employ or retain persons that are necessary to handle the financial transactions of the Association, and to perform other functions that become necessary or proper under this Article;

(5) Take legal action that may be necessary to avoid payment of improper claims;

(6) Exercise, for the purposes of this Article and to the extent approved by the Commissioner, the powers of a domestic life or health insurer, but in no case may the Association issue insurance policies or annuity contracts other than those issued to perform its obligations under this Article.

(t) The Association may join an organization of one or more other state associations of similar purposes, in order to further the purposes of this Article and administer the powers and duties of the Association. (1991, c. 681, s. 56; c. 720, s. 94.)

Editor's Note. —
This section has been set out in the supplement to correct a printing error.

§ 58-62-41. Assessments.

(a) To provide the funds necessary to carry out the powers and duties of the Association, the Board shall assess the member insurers, separately for each account, at such time and for such amounts as the Board finds necessary. Assessments are due not less than 30 days after prior written notice to the member insurers and shall accrue interest at the rate of one percent (1%) per month, or any part thereof, after the due date.

(b) There shall be two classes of assessments, as follows:

(1) Class A assessments shall be made for the purpose of meeting administrative and legal costs and other expenses and examinations conducted under the authority of G.S. 58-62-56(e). Class A assessments may be made whether or not they are related to a particular delinquent insurer.

(2) Class B assessments shall be made to the extent necessary to carry out the powers and duties of the Association under G.S. 58-62-36 with regard to a delinquent insurer.

(c) The amount of any Class A assessment shall be determined by the Board and may or may not be prorated. If prorated, the Board may provide that it be credited against future Class B assessments. If not prorated, the assessment shall not exceed one hundred fifty dollars ($150.00) per member insurer in any one calendar year. The amount of any Class B assessment shall be allocated for assessment purposes among the accounts pursuant to an allocation formula, which may be based on the premiums or reserves of the delinquent insurer or any other standard considered by the Board in its sole discretion to be fair and reasonable under the circumstances.

(d) Class B assessments against member insurers for each account and subaccount shall be in the proportion that the premiums received on business in this State by each assessed member insurer or policies covered by each account for the three most recent calendar years for which information is available preceding the year in which the insurer became delinquent, as the case may be, bears to the premiums received on business in this State for those calendar years by all assessed member insurers.

(e) Assessments for funds to meet the requirements of the Association with respect to a delinquent insurer shall not be made until necessary to implement the purposes of this Article. Classification of assessments under subsection (b) of this section and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

(f) The Association may abate or defer, in whole or in part, the assessment of a member insurer if, in the Board's opinion, payment of the assessment would endanger the member insurer's ability to fulfill its contractual obligations. If an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section.

(g) The total of all assessments upon a member insurer for the life and annuity account and for each subaccount thereunder shall not in any one calendar year exceed two percent (2%) and for the health account shall not in any one calendar year exceed two percent (2%) of the insurer's average premiums received in this State on the policies and contracts covered by the account during the three calendar years preceding the year in which an insurer became a delinquent insurer. If the maximum assessment, together with the other assets of the Association in any account, does not provide in any one year in either account an amount sufficient to carry out the Association's responsibilities, the necessary additional funds shall be assessed as soon thereafter as permitted by this Article.

(h) The Board may provide in the Plan a method of allocating funds among claims, whether relating to one or more delinquent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(i) If a one percent (1%) assessment for any subaccount of the life and annuity account in any one year does not provide an amount sufficient to carry out the Association's responsibilities, then under subsection (d) of this section, the Board shall assess all subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in subsection (g) of this section.

(j) The Board may, by an equitable method as established in the Plan, refund to member insurers, in proportion to the contribution of each insurer to that account, the amount by which the assets of the account exceed the amount the Board finds is necessary to carry out during the coming year the obligations of the Association with regard to that account, including assets accruing from assignment, subrogation, net realized gains, and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the Association and for future losses.

(k) It is proper for any member insurer, in determining its premium rates and policyowner dividends as to any kind of insurance within the scope of this Article, to consider the amount reasonably necessary to meet its assessment obligations under this Article.

(*l*) The Association shall issue to each insurer paying an assessment under this Article, other than a Class A assessment, a certificate of contribution, in a form prescribed by the Commissioner, for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. (1991, c. 681, s. 56; 1993, c. 452, ss. 61.1, 62; 1995, c. 193, ss. 47, 48.)

Editor's Note. — Session Laws 1995, c. 193, s. 67 contains a severability clause.

§ 58-62-56. Prevention of delinquencies.

(a) To aid in the detection and prevention of insurer delinquencies, it is the Commissioner's duty to:

(1) Notify insurance regulators when revoking or suspending the license of a member insurer, or making any formal order that the insurer restrict its premium writing, obtain additional contributions to surplus, withdraw from this State, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policyholders or creditors. That notice shall be sent electronically through the NAIC headquarters and mailed to all insurance regulators within 30 days following the action taken or the date on which the action occurs.

(2) Report to the Board when the Commissioner has taken any of the actions in subdivision (1) of this subsection or has received a report from another insurance regulator indicating that any such action has been taken in another state. The report to the Board shall contain all significant details of the action taken or the report received from another insurance regulator.

(3) Report to the Board when the Commissioner has reasonable cause to believe from any examination, whether completed or in process, of any member insurer that the insurer may be delinquent.

(4) Furnish the Board with the NAIC Insurance Regulatory Information System financial test ratios and a listing of companies that are not included in the ratios developed by the NAIC; and the Board may use that data in carrying out its duties and responsibilities under this section. The data shall be kept confidential by the Board until it is made public by the Commissioner or another lawful authority.

(b) The Commissioner may seek the advice and recommendations of the Board concerning any matter affecting the Commissioner's duties and responsibilities regarding the financial condition of member insurers and other entities seeking admission to transact insurance business in this State.

(c) The Board may, upon majority vote, make reports and recommendations to the Commissioner upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer or germane to the solvency of any company seeking to do an insurance business in this State. The reports and recommendations are not public records.

(d) The Board shall, upon majority vote, notify the Commissioner of any information indicating that any member insurer may be delinquent.

(e) The Board may, upon majority vote, request that the Commissioner order an examination of any member insurer that the Board in good faith believes may be delinquent. Within 30 days of the receipt of the request, the Commissioner shall begin the examination. The examination may be conducted as an NAIC examination or may be conducted by persons the Commissioner designates. The examination report shall be treated as are other examination reports. In no event shall the examination report be released to the Board before its release to the public; but this does not preclude the Commissioner from complying with subsection (a) of this section. The Commissioner shall notify the Board when the examination is completed. The request for an examination shall be kept on file by the Commissioner, but shall not be open to public inspection before the release of the examination report to the public.

(f) The Board may, upon majority vote, make recommendations to the Commissioner for the detection and prevention of insurer delinquencies.

(g) The Board shall, at the conclusion of any insurer insolvency in which the Association was obligated to pay covered claims, prepare a report to the Commissioner containing any information that it has in its possession bearing on the history and causes of the insolvency. The Board shall cooperate with the boards of directors of guaranty associations in other states in preparing a report on the history and causes of insolvency of a particular insurer, and the Board may adopt by reference any report prepared by such other associations. (1991, c. 681, s. 56; 1995, c. 360, s. 2(k).)

ARTICLE 63.

Unfair Trade Practices.

§ 58-63-1. Declaration of purpose.

CASE NOTES

Claims based on tortious acts arising from this article are unassignable personal torts. Horton v. New S. Ins. Co., 122 N.C. App. 265, 468 S.E.2d 856, cert. denied, — N.C. —, 472 S.E.2d 8 (1996).

§ 58-63-15. Unfair methods of competition and unfair or deceptive acts or practices defined.

CASE NOTES

Claims based on tortious acts arising from this article are unassignable personal torts. Horton v. New S. Ins. Co., 122 N.C. App. 265, 468 S.E.2d 856, cert. denied, — N.C. —, 472 S.E.2d 8 (1996).

A private right of action under this section and § 75-1.1 may not be asserted by a third-party claimant against the insurer of an adverse party. Wilson v. Wilson, 121 N.C. App. 662, 468 S.E.2d 495 (1996).

Third-Party Action. — Allowing a third-party action because of a violation of this section would require the insurer to act in the best interests of the party adverse to its insured and would likely put the insurer in a position of conflict with its insured. Wilson v. Wilson, 121 N.C. App. 662, 468 S.E.2d 495 (1996).

A violation of this section as a matter of law, etc. —

Violation of any form of conduct listed operates as a per se instance of unfair and deceptive trade practice under § 75-1.1. Murray v. Nationwide Mut. Ins. Co., 123 N.C. App. 1, 472 S.E.2d 358 (1996).

Subsection (11) enumerates a list of practices which are, as a matter of law, instances of unfair and deceptive conduct. Murray v. Nationwide Mut. Ins. Co., 123 N.C. App. 1, 472 S.E.2d 358 (1996).

Showing of General Business Practice. — Before there is a violation of this statute, a plaintiff must allege that a defendant has engaged in the prohibited practice with such frequency as to indicate a general business practice. Whiteville Oil Co. v. Federated Mut. Ins. Co., 889 F. Supp. 241 (E.D.N.C. 1995), aff'd, 87 F.3d 1310 (4th Cir. 1996).

Where plaintiff in underlying action failed to allege specific facts indicating that defendant engaged in any prohibited practice with sufficient frequency, as required by statute, and because North Carolina case law does not place a duty on the insurer to interpret policies for the insured, plaintiff's claim against insurer for unfair and deceptive trade practices would not be allowed to go forward. Whiteville Oil Co. v. Federated Mut. Ins. Co., 889 F. Supp. 241 (E.D.N.C. 1995), aff'd, 87 F.3d 1310 (4th Cir. 1996).

Cited in Isenhour v. Universal Underwriters Ins. Co., 341 N.C. 597, 461 S.E.2d 317 (1995); Braddy v. Nationwide Mut. Liab. Ins. Co., 122 N.C. App. 402, 470 S.E.2d 820 (1996); N.C. Steel, Inc. v. National Council on Comp. Ins., 123 N.C. App. 163, 472 S.E.2d 578 (1996); Members Interior Constr., Inc. v. Leader Constr. Co., 124 N.C. App. 121, 476 S.E.2d 399 (1996).

§ 58-63-25. Hearings, witnesses, appearances, production of books and service of process.

(a) When the Commissioner has reason to believe that any person has been engaged or is engaging in this State in any unfair method of competition or any unfair or deceptive act or practice defined in G.S. 58-63-15 or under G.S. 58-63-65, and that a proceeding by the Commissioner on the matter would be in the interest of the public, the Commissioner shall issue and serve upon the person a statement of the charges in that respect and a notice of the hearing on the matter to be held at the time and place fixed in the notice, which shall not be less than 10 days after the date of the service of the notice.

(b) At the time and place fixed for such hearing, such person shall have an opportunity to be heard and to show cause why an order should not be made by the Commissioner requiring such person to cease and desist from the acts, methods or practices so complained of. Upon good cause shown, the Commissioner shall permit any person to intervene, appear and be heard at such hearing by counsel or in person.

(c) Nothing contained in this Article shall require the observance at any such hearing of formal rules of pleading or evidence.

(d) The Commissioner, upon such hearing, may administer oaths, examine and cross-examine witnesses, receive oral and documentary evidence, and shall have the power to subpoena witnesses, compel their attendance, and require the production of books, papers, records, correspondence, or other documents which he deems relevant to the inquiry. The Commissioner, upon such hearing, may, and upon the request of any party shall, cause to be made a stenographic record of all the evidence and all the proceedings had at such hearing. If no stenographic record is made and if a judicial review is sought, the Commissioner shall prepare a statement of the evidence and proceeding for use on review. In case of a refusal of any person to comply with any subpoena issued hereunder or to testify with respect to any matter concerning which he may be lawfully interrogated, the Superior Court of Wake County, on application of the Commissioner, may issue an order requiring such person to comply with such subpoena and to testify; and any failure to obey any such order of the court may be punished by the court as a contempt thereof.

(e) Statements of charges, notices, orders, and other processes of the Commissioner under this Article may be served by anyone duly authorized by the Commissioner, either in the manner provided by law for service of process in civil actions, or by registering and mailing a copy thereof to the person affected by such statement, notice, order, or other process at his or its residence or principal office or place of business. The verified return by the person so serving such statement, notice, order, or other process, setting forth the manner of such service, shall be proof of the same, and the return postcard receipt for such statement, notice, order, or other process, registered and mailed as aforesaid, shall be proof of the service of the same. (1949, c. 1112; 1995, c. 193, s. 49.)

Editor's Note. — Session Laws 1995, c. 193, s. 67 contains a severability clause.

§ 58-63-35. Judicial review of cease and desist orders.

(a) Any person required by an order of the Commissioner under G.S. 58-63-32 to cease and desist from engaging in any unfair method of competition or any unfair or deceptive act or practice defined in G.S. 58-63-15 may obtain a review of the order by filing in the Superior Court of Wake County, within 30 days from the date of the service of such order, a written petition praying that the order of the Commissioner be set aside. A copy of the petition shall be immediately served upon the Commissioner, and at that time the Commissioner immediately shall certify and file in the court a transcript of the entire record in the proceeding, including all the evidence taken and the report and order of the Commissioner. Upon the filing of the petition and transcript, the court has jurisdiction of the proceeding and of the question determined therein, shall determine whether the filing of the petition shall operate as a stay of the Commissioner's order, and has power to make and enter upon the pleadings, evidence, and proceedings set forth in the transcript a decree modifying, affirming or reversing the order of the Commissioner, in whole or in part. The findings of the Commissioner as to the facts, if supported by substantial evidence, are conclusive.

(b) To the extent that the order of the Commissioner is affirmed, the court shall thereupon issue its own order commanding obedience to the terms of such order of the Commissioner. If either party shall apply to the court for leave to adduce additional evidence, and shall show to the satisfaction of the court that such additional evidence is material and that there were reasonable grounds for the failure to adduce such evidence in the proceeding before the Commissioner, the court may order such additional evidence to be taken before the Commissioner and to be adduced upon the hearing in such manner and upon such terms and conditions as to the court may seem proper. The Commissioner may modify his findings of fact, or make new findings by reason of the additional evidence so taken, and he shall file such modified or new findings which, if supported by substantial evidence shall be conclusive, and his recommendations, if any, for the modification or setting aside of his original order, with the return of such additional evidence.

(c) A cease and desist order issued by the Commissioner under G.S. 58-63-30 shall become final:

(1) Upon the expiration of the time allowed for filing a petition for review if no such petition has been duly filed within such time; except that the Commissioner may thereafter modify or set aside his order to the extent provided in G.S. 58-63-30(b); or

(2) Upon the final decision of the court if the court directs that the order of the Commissioner be affirmed or the petition for review dismissed.

(d) No order of the Commissioner under this Article or order of a court to enforce the same shall in any way relieve or absolve any person affected by such order from any liability under any other laws of this State. (1949, c. 1112; 1995, c. 193, s. 50.)

Editor's Note. — Session Laws 1995, c. 193, s. 67 contains a severability clause.

CASE NOTES

Applied in N.C. Steel, Inc. v. National Council on Comp. Ins., 123 N.C. App. 163, 472 S.E.2d 578 (1996).

§ 58-63-50. Penalty.

Any person who willfully violates a cease and desist order of the Commissioner under G.S. 58-63-32, after it has become final, and while the order is in effect, shall forfeit and pay to the Commissioner for the use of the public schools of the county or counties in which the act or acts complained of occurred the sum of not less than one thousand dollars ($1,000) nor more than five thousand dollars ($5,000) for each violation, which if not paid shall be recovered in a civil action instituted in the name of the Commissioner in the Superior Court of Wake County. (1949, c. 1112; 1985, c. 666, s. 21; 1991, c. 720, ss. 33, 63; 1995, c. 193, s. 51.)

Editor's Note. — Session Laws 1995, c. 193, s. 67 contains a severability clause.

§§ 58-63-66 through 58-63-69: Reserved for future codification purposes.

§ 58-63-70. Health care service discount practices by insurers and service corporations.

(a) It is an unfair trade practice for any insurer or service corporation subject to this Chapter to make an intentional misrepresentation to a health care provider to the effect that the insurer or service corporation is entitled to a certain preferred provider or other discount off the fees charged for medical services, procedures, or supplies provided by the health care provider, when the insurer or service corporation is not entitled to any discount or is entitled to a lesser discount from the provider on those fees.

(b) It is an unfair trade practice for any person with knowledge that an insurer or service corporation intends to make the type of misrepresentation prohibited in subsection (a) of this section to provide substantial assistance to that insurer or service corporation in accomplishing that misrepresentation. (1997-519, s. 3.2.)

Editor's Note. — Session Laws 1997-519, s. 5, made this section effective January 1, 1998.

Article 64.

Registration, Disclosure, Contract, and Financial Monitoring Requirements for Continuing Care Facilities.

§ 58-64-33. Operating reserves.

(a) All continuing care facilities shall maintain after opening: operating reserves equal to fifty percent (50%) of the total operating costs projected for the 12-month period following the period covered by the most recent annual statement filed with the Department. The forecast statements as required by G.S. 58-64-20(a)(12) shall serve as the basis for computing the operating reserve. In addition to total operating expenses, total operating costs will include debt service, consisting of principal and interest payments along with taxes and insurance on any mortgage loan or other long-term financing, but will exclude depreciation, amortized expenses, and extraordinary items as approved by the Commissioner. If the debt service portion is accounted for by way of another reserve account, the debt service portion may be excluded. Facilities that maintain an occupancy level in excess of ninety percent (90%) shall only be required to maintain twenty-five percent (25%) operating reserve upon approval of the Commissioner, unless otherwise instructed by the Commissioner. The operating reserves may be funded by cash, by invested cash, or by investment grade securities, including bonds, stocks, U.S. Treasury obligations, or obligations of U.S. government agencies.

(b) A provider that has begun construction or has permanent financing in place or is in operation on the effective date of this section has up to five years to meet the operating reserve requirements.

(c) Operating reserves shall only be released upon the submittal of a detailed request from the provider or facility and must be approved by the Commissioner. Such requests must be submitted in writing for the Commissioner to review at least 10 business days prior to the date of withdrawal. (1991, c. 196, s. 5; c. 720, s. 89; 1993, c. 452, s. 64; 1993 (Reg. Sess., 1994), c. 678, s. 29; 1995, c. 193, s. 52.)

Editor's Note. —
Session Laws 1995, c. 193, s. 67 contains a severability clause.

§ 58-64-45. Supervision, rehabilitation, and liquidation.

(a) If, at any time, the Commissioner determines, after notice and an opportunity for the provider to be heard, that:

(1) A portion of an entrance fee escrow account required to be maintained under this Article has been or is proposed to be released in violation of this Article;

(2) A provider has been or will be unable, in such a manner as may endanger the ability of the provider, to fully perform its obligations pursuant to contracts for continuing care, to meet the projected financial data previously filed by the provider;

(3) A provider has failed to maintain the escrow account required under this Article; or

(4) A facility is bankrupt or insolvent, or in imminent danger of becoming bankrupt or insolvent;

the Commissioner may commence a supervision proceeding pursuant to Article 30 of this Chapter or may apply to the Superior Court of Wake County or to the federal bankruptcy court that may have previously taken jurisdiction over the provider or facility for an order directing the Commissioner or authorizing the Commissioner to rehabilitate or to liquidate a facility in accordance with Article 30 of this Chapter.

(b) The definition of "insolvency" or "insolvent" in G.S. 58-30-10(13) shall not apply to facilities under this Article. Rules adopted by the Commissioner shall define and describe "insolvency" or "hazardous financial condition" for facilities under this Article. G.S. 58-30-12 shall not apply to facilities under this Article.

(c) If, at any time, the Court finds, upon petition of the Commissioner or provider, or on its own motion, that the objectives of an order to rehabilitate a facility have been accomplished and that the facility can be returned to the provider's management without further jeopardy to the residents of the facility, the Court may, upon a full report and accounting of the conduct of the facility's affairs during the rehabilitation and of the facility's current financial condition, terminate the rehabilitation and, by order, return the facility and its assets and affairs to the provider's management.

(d), (e) Repealed by Session Laws 1995 (Regular Session, 1996), c. 582, s. 3, effective October 1, 1996.

(f) In applying for an order to rehabilitate or liquidate a facility, the Commissioner shall give due consideration in the application to the manner in which the welfare of persons who have previously contracted with the provider for continuing care may be best served.

(g) An order for rehabilitation shall be refused or vacated if the provider posts a bond, by a recognized surety authorized to do business in this State and executed in favor of the Commissioner on behalf of persons who may be found entitled to a refund of entrance fees from the provider or other damages in the event the provider is unable to fulfill its contracts to provide continuing care at the facility, in an amount determined by the Court to be equal to the reserve funding that would otherwise need to be available to fulfill such obligations. (1989, c. 758, s. 1; 1995 (Reg. Sess., 1996), c. 582, s. 3.)

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective October 1, 1996, and applicable to continuing care retirement centers that are determined by the Commissioner of Insurance to be financially impaired on or after that date, substituted "Supervision, rehabilitation, and liquidation" for "Rehabilitation or liquidation" in the catchline; in subsection (a) inserted "commence a supervision proceeding pursuant to Article 30 of this Chapter or may", deleted "appoint a trustee" preceding "to rehabilitate or to liquidate", and added "in accordance with Article 30 of this Chapter" at the end; rewrote subsection (b); substituted "Commissioner" for "Commissioner, trustee" in subsection (c); deleted subsection (d), which read "If, at any time, the Commissioner determines that further efforts to rehabilitate the provider would be useless, the Commissioner may apply to the Court for an order of liquidation"; deleted subsection (e), regarding an order to liquidate a facility; and deleted "under this section" preceding "shall be refused" in subsection (g).

§ 58-64-55. Examinations; financial statements.

The Commissioner or the Commissioner's designee may, in the Commissioner's discretion, visit a facility offering continuing care in this State to examine its books and records. Expenses incurred by the Commissioner in conducting examinations under this section shall be paid by the facility examined. The provisions of G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-155, 58-2-165, 58-2-180, 58-2-185, 58-2-190, and 58-6-5 apply to this Article and are hereby incorporated by reference. (1989, c. 758, s. 1; 1995, c. 193, s. 53.)

Editor's Note. — Session Laws 1995, c. 193, s. 67 contains a severability clause.

§ 58-64-60. Agreements as preferred claims on liquidation.

In the event of liquidation of a provider, all continuing care agreements executed by the provider shall be deemed preferred claims against all assets owned by the provider; provided, however, such claims shall be subordinate to the liquidator's cost of administration or any secured claim. (1989, c. 758, s. 1; 1995 (Reg. Sess., 1996), c. 582, s. 4.)

Effect of Amendments: — The 1995 (Reg. Sess., 1996) amendment, effective October 1, 1996, and applicable to continuing care retirement centers that are determined by the Commissioner of Insurance to be financially impaired on or after that date, inserted "the liquidator's cost of administration or".

§ 58-64-70. Civil liability.

(a) A provider who enters into a contract for continuing care at a facility without having first delivered a disclosure statement meeting the requirements of G.S. 58-64-20 to the person contracting for this continuing care, or enters into a contract for continuing care at a facility with a person who has relied on a disclosure statement that omits to state a material fact required to be stated therein or necessary in order to make the statements made therein, in light of the circumstances under which they are made, not misleading, shall be liable to the person contracting for this continuing care for actual damages and repayment of all fees paid to the provider, facility, or person violating this Article, less the reasonable value of care and lodging provided to the resident by or on whose behalf the contract for continuing care was entered into prior to discovery of the violation, misstatement, or omission or the time the violation, misstatement, or omission should reasonably have been discovered, together with interest thereon at the legal rate for judgments, and court costs and reasonable attorney fees.

(b) Liability under this section exists regardless of whether the provider or person liable had actual knowledge of the misstatement or omission.

(c) A person may not file or maintain an action under this section if the person, before filing the action, received a written offer of a refund of all amounts paid the provider, facility, or person violating this Article together with interest at the rate established monthly by the Commissioner of Banks pursuant to G.S. 24-1.1(c), less the current contractual value of care and lodging provided prior to receipt of the offer, and if the offer recited the provisions of this section and the recipient of the offer failed to accept it within 30 days of actual receipt.

(d) An action may not be maintained to enforce a liability created under this Article unless brought before the expiration of three years after the execution of the contract for continuing care that gave rise to the violation. (1989, c. 758, s. 1; 1995, c. 193, s. 54.)

Editor's Note. — Session Laws 1995, c. 193, s. 67 contains a severability clause.

§ 58-64-85. Other licensing or regulation.

Nothing in this Article affects the authority of the Department of Health and Human Services or any successor agency otherwise provided by law to license or regulate any health service facility or domiciliary service facility. (1991, c. 720, s. 1; 1997-443, s. 11A.118(a).)

Editor's Note. — Session Laws 1997-443, s. 1.1, provides: "This act shall be known as 'The Current Operations and Capital Improvements Appropriations Act of 1997'".

Session Laws 1997-443, s. 35.4, is a severability clause.

Effect of Amendments. — The 1997 amendment, effective August 28, 1997, substituted "Health and Human Services" for "Human Resources."

ARTICLE 65.

Hospital, Medical and Dental Service Corporations.

Part 1. In General.

§ 58-65-1. (Effective until July 1, 1999) Regulation and definitions; application of other laws; profit and foreign corporations prohibited.

(a) **(See editor's note)** Any corporation heretofore or hereafter organized under the general corporation laws of the State of North Carolina for the purpose of maintaining and operating a nonprofit hospital and/or medical and/or dental service plan whereby hospital care and/or medical and/or dental service may be provided in whole or in part by said corporation or by hospitals and/or physicians and/or dentists participating in such plan, or plans, shall be governed by this Article and Article 66 of this Chapter and shall be exempt from all other provisions of the insurance laws of this State, heretofore enacted, unless specifically designated herein, and no laws hereafter enacted shall apply to them unless they be expressly designated therein.

The term "hospital service plan" as used in this Article and Article 66 of this Chapter includes the contracting for certain fees for, or

§ 58-65-1 is set out twice. See notes.

furnishing of, hospital care, laboratory facilities, X-ray facilities, drugs, appliances, anesthesia, nursing care, operating and obstetrical equipment, accommodations and/or any and all other services authorized or permitted to be furnished by a hospital under the laws of the State of North Carolina and approved by the North Carolina Hospital Association and/or the American Medical Association.

The term "medical service plan" as used in this Article and Article 66 of this Chapter includes the contracting for the payment of fees toward, or furnishing of, medical, obstetrical, surgical and/or any other professional services authorized or permitted to be furnished by a duly licensed physician, except that in any plan in any policy of insurance governed by this Article and Article 66 of this Chapter that includes services which are within the scope of practice of a duly licensed optometrist, a duly licensed chiropractor, a duly licensed psychologist, a duly licensed pharmacist, an advanced practice registered nurse, a duly certified clinical social worker, a duly certified fee-based practicing pastoral counselor, and a duly licensed physician, then the insured or beneficiary shall have the right to choose the provider of the care or service, and shall be entitled to payment of or reimbursement for such care or service, whether the provider be a duly licensed optometrist, a duly licensed chiropractor, a duly licensed psychologist, a duly licensed pharmacist, an advanced practice registered nurse, a duly certified clinical social worker, a duly certified fee-based practicing pastoral counselor, or a duly licensed physician notwithstanding any provision to the contrary contained in such policy. The term "medical services plan" also includes the contracting for the payment of fees toward, or furnishing of, professional medical services authorized or permitted to be furnished by a duly licensed provider of health services licensed under Chapter 90 of the General Statutes.

(b) Payment or reimbursement is required by this section for a service performed by an advanced practice registered nurse only when:

(1) The service performed is within the nurse's lawful scope of practice;
(2) The policy currently provides benefits for identical services performed by other licensed health care providers;
(3) The service is not performed while the nurse is a regular employee in an office of a licensed physician;
(4) The service is not performed while the registered nurse is employed by a nursing facility (including a hospital, skilled nursing facility, intermediate care facility, or home care agency); and
(5) Nothing in this section is intended to authorize payment to more than one provider for the same service.

No lack of signature, referral, or employment by any other health care provider may be asserted to deny benefits under this provision.

(b1) Payment or reimbursement is required by this section for a service performed by a duly licensed pharmacist only when:

(1) The service performed is within the lawful scope of practice of the pharmacist;
(2) The service performed is not initial counseling services required under State or federal law or regulation of the North Carolina Board of Pharmacy;

§ 58-65-1 is set out twice. See notes.

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(3) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and

(4) The service is identified as a separate service that is performed by other licensed health care providers and is reimbursed by identical payment methods.

Nothing in this subsection authorizes payment to more than one provider for the same service.

(c) **(See editor's note)** For purposes of this section, an "advanced practice registered nurse" means only a registered nurse who is duly licensed or certified as a nurse practitioner, clinical specialist in psychiatric and mental health nursing, or nurse midwife.

For the purposes of this section, a "duly certified clinical social worker" is a "certified clinical social worker" as defined in G.S. 90B-3(2) and certified by the North Carolina Certification Board for Social Work pursuant to Chapter 90B of the General Statutes.

For purposes of this section, a "duly certified fee-based practicing pastoral counselor" shall be defined only to include fee-based practicing pastoral counselors certified by the North Carolina State Board of Examiners of Fee-Based Practicing Pastoral Counselors pursuant to Article 26 of Chapter 90 of the General Statutes.

For the purposes of this section, a "duly licensed psychologist" shall be defined only to include a psychologist who is duly licensed in the State of North Carolina and has a doctorate degree in psychology and at least two years clinical experience in a recognized health setting, or has met the standards of the National Register of Health Providers in Psychology. After January 1, 1995, a duly licensed psychologist shall be defined as a licensed psychologist who holds permanent licensure and certification as a health services provider psychologist issued by the North Carolina Psychology Board.

The term "dental service plan" as used in this Article and Article 66 of this Chapter includes contracting for the payment of fees toward, or furnishing of dental and/or any other professional services authorized or permitted to be furnished by a duly licensed dentist.

The insured or beneficiary of every "medical service plan" and of every "dental service plan," as those terms are used in this Article and Article 66 of this Chapter, or of any policy of insurance issued thereunder, that includes services which are within the scope of practice of both a duly licensed physician and a duly licensed dentist shall have the right to choose the provider of such care or service, and shall be entitled to payment of or reimbursement for such care or service, whether the provider be a duly licensed physician or a duly licensed dentist notwithstanding any provision to the contrary contained in any such plan or policy.

The term "hospital service corporation" as used in this Article and Article 66 of this Chapter is intended to mean any nonprofit corporation operating a hospital and/or medical and/or dental service plan, as herein defined. Any corporation heretofore or hereafter organized and coming within the provisions of this Article and Article 66 of this Chapter, the certificate of incorporation of which authorizes the operation of either a hospital or medical and/or dental service plan, or any or all of them, may, with the approval of

§ 58-65-1 is set out twice. See notes.

the Commissioner of Insurance, issue subscribers' contracts or certificates approved by the Commissioner of Insurance, for the payment of either hospital or medical and/or dental fees, or the furnishing of such services, or any or all of them, and may enter into contracts with hospitals for physicians and/or dentists, or any or all of them, for the furnishing of fees or services respectively under a hospital or medical and/or dental service plan, or any or all of them.

The term "preferred provider" as used in this Article and Article 66 of this Chapter with respect to contracts, organizations, policies or otherwise means a health care service provider who has agreed to accept, from a corporation organized for the purposes authorized by this Article and Article 66 of this Chapter or other applicable law, special reimbursement terms in exchange for providing services to beneficiaries of a plan administered pursuant to this Article and Article 66 of this Chapter. Except to the extent prohibited either by G.S. 58-65-140 or by regulations promulgated by the Department of Insurance not inconsistent with this Article and Article 66 of this Chapter, the contractual terms and conditions for special reimbursement shall be those which the corporation and preferred provider find to be mutually agreeable.

(d) No foreign or alien hospital or medical and/or dental service corporation as herein defined shall be authorized to do business in this State. (1941, c. 338, s. 1; 1943, c. 537, s. 1; 1953, c. 1124, s. 1; 1961, c. 1149; 1965, c. 396, s. 1; c. 1169, s. 1; 1967, c. 690, s. 1; 1973, c. 642; 1977, c. 601, ss. 1, 3½; 1985, c. 735, s. 2; 1993, c. 347, s. 3; c. 375, s. 4; 464, s. 3.1; 1995, c. 223, s. 2; c. 406, s. 4; 1997-197, ss. 1, 2.)

Section Set Out Twice. — The section above is effective until July 1, 1999. For the section as amended effective July 1, 1999, see the following section, also numbered § 58-65-1.

Editor's Note. — Section 58-65-140 referred to in subsection (c) has been repealed.

Session Laws 1993, c. 347, s. 5 provided that the amendment by c. 347, s. 3 applied to all plans and policies with an inception, renewal, or anniversary date on or after October 1, 1993, and expired October 1, 1998. The expiration date was deleted by Session Laws 1997-197, s. 1.

Session Laws 1993, c. 464, s. 8 provided that s. 3.1 of c. 464, which amended this section, would expire June 30, 1999. The expiration date was deleted by Session Laws 1997-197, s. 2.

Session Laws 1995, c. 406, s. 6, provides that the amendments to this section by Session Laws 1995, c. 406, s. 4, expire July 1, 1999. Session Laws 1995, c. 406, s. 4, amended the third paragraph of subsection (a) by adding both occurrences of "a duly certified fee-based practicing pastoral counselor" following "a duly certified clinical social worker" in the first sentence of that paragraph, and added the third paragraph of subsection (c) regarding duly certified fee-based practicing pastoral counselors.

Session Laws 1995, c. 223, s. 2, which amended this section, was effective July 1, 1995, and applicable to claims for payment or reimbursement for services rendered on or after that date.

Session Laws 1997-483, s. 12.1, provides: "Notwithstanding any other provision of law, no hospital, medical, and dental service corporation may convert to a mutual nonstock or stock accident and health insurance company or life insurance company prior to August 1, 1998. For the purposes of this section, 'convert to a mutual nonstock or stock accident and health insurance company or life insurance company' includes a restructuring that is determined by the Commissioner of Insurance to constitute the disposition of a substantial amount of the corporation's assets to an entity other than a nonprofit entity, except for the disposition of assets in the ordinary course of business."

Session Laws 1997-483, s. 1, provides: "This act shall be known as 'The Studies Act of 1997.'"

Session Laws 1997-483, s. 17.1, provides: "Except as otherwise specifically provided, this act becomes effective July 1, 1997. If a study is authorized both in this act and the Current Operations Appropriations Act of 1997 [Session Laws 1997-443], the study shall be implemented in accordance with the Current Operations Appropriations Act of 1997 as ratified."

§ 58-65-1. (Effective July 1, 1999) Regulation and definitions; application of other laws; profit and foreign corporations prohibited.

(a) **(See editor's note)** Any corporation heretofore or hereafter organized under the general corporation laws of the State of North Carolina for the purpose of maintaining and operating a nonprofit hospital and/or medical and/or dental service plan whereby hospital care and/or medical and/or dental service may be provided in whole or in part by said corporation or by hospitals and/or physicians and/or dentists participating in such plan, or plans, shall be governed by this Article and Article 66 of this Chapter and shall be exempt from all other provisions of the insurance laws of this State, heretofore enacted, unless specifically designated herein, and no laws hereafter enacted shall apply to them unless they be expressly designated therein.

The term "hospital service plan" as used in this Article and Article 66 of this Chapter includes the contracting for certain fees for, or furnishing of, hospital care, laboratory facilities, X-ray facilities, drugs, appliances, anesthesia, nursing care, operating and obstetrical equipment, accommodations and/or any and all other services authorized or permitted to be furnished by a hospital under the laws of the State of North Carolina and approved by the North Carolina Hospital Association and/or the American Medical Association.

The term "medical service plan" as used in this Article and Article 66 of this Chapter includes the contracting for the payment of fees toward, or furnishing of, medical, obstetrical, surgical and/or any other professional services authorized or permitted to be furnished by a duly licensed physician, except that in any plan in any policy of insurance governed by this Article and Article 66 of this Chapter that includes services which are within the scope of practice of a duly licensed optometrist, a duly licensed chiropractor, a duly licensed psychologist, a duly licensed pharmacist, an advanced practice registered nurse, a duly certified clinical social worker, and a duly licensed physician, then the insured or beneficiary shall have the right to choose the provider of the care or service, and shall be entitled to payment of or reimbursement for such care or service, whether the provider be a duly licensed optometrist, a duly licensed chiropractor, a duly licensed psychologist, a duly licensed pharmacist, an advanced practice registered nurse, a duly certified clinical social worker, or a duly licensed physician notwithstanding any provision to the contrary contained in such policy. The term "medical services plan" also includes the contracting for the payment of fees toward, or furnishing of, professional medical services authorized or permitted to be furnished by a duly licensed provider of health services licensed under Chapter 90 of the General Statutes.

§ 58-65-1 is set out twice. See notes.

(b) Payment or reimbursement is required by this section for a service performed by an advanced practice registered nurse only when:

(1) The service performed is within the nurse's lawful scope of practice;
(2) The policy currently provides benefits for identical services performed by other licensed health care providers;
(3) The service is not performed while the nurse is a regular employee in an office of a licensed physician;
(4) The service is not performed while the registered nurse is employed by a nursing facility (including a hospital, skilled nursing facility, intermediate care facility, or home care agency); and
(5) Nothing in this section is intended to authorize payment to more than one provider for the same service.

No lack of signature, referral, or employment by any other health care provider may be asserted to deny benefits under this provision.

(b1) Payment or reimbursement is required by this section for a service performed by a duly licensed pharmacist only when:

(1) The service performed is within the lawful scope of practice of the pharmacist;
(2) The service performed is not initial counseling services required under State or federal law or regulation of the North Carolina Board of Pharmacy;
(3) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and
(4) The service is identified as a separate service that is performed by other licensed health care providers and is reimbursed by identical payment methods.

Nothing in this subsection authorizes payment to more than one provider for the same service.

(c) **(See editor's note)** For purposes of this section, an "advanced practice registered nurse" means only a registered nurse who is duly licensed or certified as a nurse practitioner, clinical specialist in psychiatric and mental health nursing, or nurse midwife.

For the purposes of this section, a "duly certified clinical social worker" is a "certified clinical social worker" as defined in G.S. 90B-3(2) and certified by the North Carolina Certification Board for Social Work pursuant to Chapter 90B of the General Statutes.

For the purposes of this section, a "duly licensed psychologist" shall be defined only to include a psychologist who is duly licensed in the State of North Carolina and has a doctorate degree in psychology and at least two years clinical experience in a recognized health setting, or has met the standards of the National Register of Health Providers in Psychology. After January 1, 1995, a duly licensed psychologist shall be defined as a licensed psychologist who holds permanent licensure and certification as a health services provider psychologist issued by the North Carolina Psychology Board.

The term "dental service plan" as used in this Article and Article 66 of this Chapter includes contracting for the payment of fees toward, or furnishing of dental and/or any other professional ser-

§ 58-65-1 is set out twice. See notes.

vices authorized or permitted to be furnished by a duly licensed dentist.

The insured or beneficiary of every "medical service plan" and of every "dental service plan," as those terms are used in this Article and Article 66 of this Chapter, or of any policy of insurance issued thereunder, that includes services which are within the scope of practice of both a duly licensed physician and a duly licensed dentist shall have the right to choose the provider of such care or service, and shall be entitled to payment of or reimbursement for such care or service, whether the provider be a duly licensed physician or a duly licensed dentist notwithstanding any provision to the contrary contained in any such plan or policy.

The term "hospital service corporation" as used in this Article and Article 66 of this Chapter is intended to mean any nonprofit corporation operating a hospital and/or medical and/or dental service plan, as herein defined. Any corporation heretofore or hereafter organized and coming within the provisions of this Article and Article 66 of this Chapter, the certificate of incorporation of which authorizes the operation of either a hospital or medical and/or dental service plan, or any or all of them, may, with the approval of the Commissioner of Insurance, issue subscribers' contracts or certificates approved by the Commissioner of Insurance, for the payment of either hospital or medical and/or dental fees, or the furnishing of such services, or any or all of them, and may enter into contracts with hospitals for physicians and/or dentists, or any or all of them, for the furnishing of fees or services respectively under a hospital or medical and/or dental service plan, or any or all of them.

The term "preferred provider" as used in this Article and Article 66 of this Chapter with respect to contracts, organizations, policies or otherwise means a health care service provider who has agreed to accept, from a corporation organized for the purposes authorized by this Article and Article 66 of this Chapter or other applicable law, special reimbursement terms in exchange for providing services to beneficiaries of a plan administered pursuant to this Article and Article 66 of this Chapter. Except to the extent prohibited either by G.S. 58-65-140 or by regulations promulgated by the Department of Insurance not inconsistent with this Article and Article 66 of this Chapter, the contractual terms and conditions for special reimbursement shall be those which the corporation and preferred provider find to be mutually agreeable.

(d) No foreign or alien hospital or medical and/or dental service corporation as herein defined shall be authorized to do business in this State. (1941, c. 338, s. 1; 1943, c. 537, s. 1; 1953, c. 1124, s. 1; 1961, c. 1149; 1965, c. 396, s. 1; c. 1169, s. 1; 1967, c. 690, s. 1; 1973, c. 642; 1977, c. 601, ss. 1, 3½; 1985, c. 735, s. 2; 1993, c. 347, s. 3; c. 375, s. 4; c. 464, s. 3.1; 1995, c. 223, s. 2; c. 406, s. 4.)

Section Set Out Twice. — The section above is effective July 1, 1999. For the section as in effect until July 1, 1999, see the preceding section, also numbered § 58-65-1.

Editor's Note. — Section 58-65-140 referred to in subsection (c) has been repealed.

Session Laws 1993, c. 347, s. 3, which amended this section, was to expire October 1, 1998. The expiration date was deleted by Session Laws 1997-197, s. 1.

Session Laws 1993, c. 464, s. 8 provided that s. 3.1 of c. 464, which amended this section by inserting the subsection designations, twice inserting "a duly certified clinical social worker" in the third paragraph of subsection (a), and adding the first paragraph of subsection (c), would expire June 30, 1999. The expiration date was deleted by Session Laws 1997-197, s. 2.

Session Laws 1995, c. 406, s. 6, provides that the amendments to this section by Session Laws 1995, c. 406, s. 4, expire July 1, 1999. Session Laws 1995, c. 406, s. 4, amended the third paragraph of subsection (a) by adding both occurrences of "a duly certified fee-based practicing pastoral counselor" following "a duly certified clinical social worker" in the first sentence of that paragraph, and added the third paragraph of subsection (c) regarding duly certified fee-based practicing pastoral counselors.

Session Laws 1995, c. 223, s. 2, which amended this section, was effective July 1, 1995, and applicable to claims for payment or reimbursement for services rendered on or after that date.

§ 58-65-25. Hospital, physician and dentist contracts.

(a) Any corporation organized under this Article may enter into contracts for the rendering of hospital service to any of its subscribers by hospitals approved by the American Medical Association and/or the North Carolina Hospital Association, and may enter into contracts for the furnishing of, or the payment in whole or in part for, medical and/or dental services rendered to any of its subscribers by duly licensed physicians and/or dentists. All obligations arising under contracts issued by such corporations to its subscribers shall be satisfied by payments made directly to the hospitals or hospitals and/or physicians and/or dentists rendering such service, or direct to the subscriber or his, her, or their legal representatives upon the receipt by the corporation from the subscriber of a statement marked paid by the hospital(s) and/or physician(s) and/or dentist(s) or both rendering such service, and all such payments heretofore made are hereby ratified. Nothing in this section shall be construed to discriminate against hospitals conducted by other schools of medical practice.

(b) All certificates, plans or contracts issued to subscribers or other persons by hospital and medical and/or dental service corporations operating under this Article shall contain in substance a provision as follows: "After two years from the date of issue of this certificate, contract or plan no misstatements, except fraudulent misstatements made by the applicant in the application for such certificate, contract or plan, shall be used to void said certificate, contract or plan, or to deny a claim for loss incurred or disability (as therein defined) commencing after the expiration of such two-year period." (1941, c. 338, s. 3; 1943, c. 537, s. 2; 1947, c. 820, s. 1; 1955, c. 850, s. 7; 1961, c. 1149; 1979, c. 755, s. 17; 1997-259, s. 16.)

Editor's Note. — Session Laws 1997-259, s. 25, provides: "Sections 1 through 18 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after July 1, 1997. Sections 19, 20, 21, 22, and 23 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after January 1, 1998. For the purposes of this act, renewal of a contract is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the contract."

Effect of Amendments. — The 1997 amendment, effective July 1, 1997, inserted subsection designations (a) and (b); in subsection (a) substituted "under this Article" for "under the provisions of this Article and Article 66 of this Chapter" preceding "may enter into", and substituted "in this section" for "herein" preceding "shall be construed"; in subsection (b) substituted "All" for "On and after January 1, 1956, all" at the beginning, deleted "and Article 66 of this Chapter" preceding "shall contain in", and deleted the last sentence which read: "No claim for loss incurred or disability (as defined in the certificate, contract or plan) commencing after two years from the date of issue of this certificate, contract or plan shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specifically described, effective on the date of loss, had existed prior to the effective date of coverage of this certificate, contract or plan". For applicability, see Editor's note.

§ 58-65-35. Nurses' services.

No agency, institution or physician providing a service for which payment or reimbursement is required to be made under a contract governed by this Article and Article 66 of this Chapter shall be denied such payment or reimbursement on account of the fact that the service was rendered through a registered nurse acting under authority of rules and regulations adopted by the North Carolina Medical Board and the Board of Nursing pursuant to G.S. 90-6 and 90-171.23. (1973, c. 436; 1991, c. 720, s. 37; 1993, c. 347, s. 4; 1995, c. 94, s. 4; 1997-197, s. 1.)

Editor's Note. — Session Laws 1993, c. 347, s. 5 provided that the amendment by c. 347, s. 2 applied to all plans and policies with an inception, renewal, or anniversary date on or after October 1, 1993, and expired October 1, 1998. The expiration date was deleted by Session Laws 1997-197, s. 1.

Effect of Amendments. — The 1995 amendment, effective May 22, 1995, substituted "North Carolina Medical Board" for "Board of Medical Examiners".

§ 58-65-55. Issuance of certificate.

Editor's Note. —

Session Laws 1995, c. 507, s. 1.1, provides that this act shall be known and cited as the Expansion and Capital Improvements Appropriations Act of 1995.

Session Laws 1995, c. 507, s. 28.9, provides: "Except for statutory changes or other provisions that clearly indicate an intention to have effects beyond the 1995-97 fiscal biennium, the textual provisions of this act apply only to funds appropriated for, and activities occurring during, the 1995-97 biennium."

Session Laws 1995, c. 507, s. 11A(c), amended Session Laws 1989 (Reg. Sess., 1990), c. 1069, s. 31, deleting the last sentence regarding the expiration of amendments to the General Statutes by Session Laws 1989 (Reg. Sess., 1990), c. 1069, if the legislature did not appropriate or transfer funds. Session Laws 1989 (Reg. Sess., 1990), s. 31, as amended by Session Laws 1995, c. 507, s. 11A(c), provides: "Section 23 [see § 58-36-70] of this act does not apply to the 1990 automobile rate filing made pursuant to Article 36 of Chapter 58 of the General Statutes. Section 27 [§ 143-3.6] of this act shall expire at the end of the 1993-1994 fiscal year and Section 28 [§ 143-3.7] shall become effective upon the expiration of Section 27."

§ 58-65-60. Subscribers' contracts; required and prohibited provisions.

(a) Every contract made by a corporation subject to the provisions of this Article and Article 66 of this Chapter shall be for a period not to exceed 12 months, and no contract shall be made providing for the inception of benefits at a date later than one year from the date of the contract. Any such contract may provide that it shall be automatically renewed for a similar period unless there shall have been one month's prior written notice of termination by either the subscriber or the corporation.

(b) Contracts may be issued that entitle one or more persons to benefits under those contracts. Persons entitled to benefits under those contracts, other than the certificate holder, may only be the certificate holder's spouse, lawful or legally adopted child of the certificate holder or the certificate holder's spouse, or any other person who resides in the same household with the certificate holder and is dependent upon the certificate holder.

(c) Every contract entered into by any such corporation with any subscriber thereof shall be in writing and a certificate stating the terms and conditions thereof shall be furnished to the subscriber to be kept by him. No such certificate form, other than to group subscribers of groups of 10 or more certificate holders or those issued pursuant to a master group contract covering 10 or more certificate holders shall be made, issued or delivered in this State unless it contains the following provisions, provided, however, groups between five and 10 certificate holders complying with and maintaining eligibility status under regulations approved by the Commissioner of Insurance for group enrollment may be cancelled if such participation falls below the minimum participation of five certificate holders; or if the group takes other group hospital, medical or surgical coverage:

(1) A statement of the amount payable to the corporation by the subscriber and the times at which and manner in which such amount is to be paid; this provision may be inserted in the application rather than in the certificate. Application need not be attached to certificate.

(2) A statement of the nature of the benefits to be furnished and the period during which they will be furnished.

(3) A statement of the terms and conditions, if any, upon which the contract may be cancelled or otherwise terminated at the option of either party. Said statement shall be in the following language:

a. "Renewability": Any contract subject to the provisions hereof is renewable at the option of the subscriber unless sufficient notice in writing of nonrenewal is mailed to the subscriber by the corporation addressed to the last address recorded with the corporation.

b. "Sufficient notice" shall be as follows:

1. During the first year of any such contract, or during the first year following any lapse and reinstatement, or reenrollment, a period of 30 days.

2. During the second and subsequent years of continuous coverage, a number of full calendar months most nearly equivalent to one fourth the number of months of continuous coverage from the first anniversary of the date of issue or reinstatement or reenrollment, whichever date is more recent, to the date of mailing of such notice.

3. No period of required notice shall exceed two years, and no renewal hereunder shall renew any such contract for any period beyond the required period of notice except by written agreement of the subscriber and corporation.

Any such contract may be modified, terminated or cancelled by the corporation at any time at its option, upon:

a. Nonpayment of fees or dues as required, or

b. Failure or refusal to comply with rate or benefit changes approved by the State Insurance Department after public hearing as outlined in G.S. 58-65-45.

c. Failure or refusal after 30 days' written notice to subscriber to transfer into hospital and medical and/or dental service plan serving the area to which he has changed residence and is eligible for or to which corporation is required to transfer by interplan agreement of transfer.

d. The provisions of these amendments to subsection (c) and (c)(3) shall apply only to such contracts as are first issued on and after January 1, 1956.

(4) A statement that the contract includes the endorsement thereon and attached papers, if any, and together with the applications contains the entire contract.

(5) A statement that if the subscriber defaults in making any payment, under the contract, the subsequent acceptance of a payment by the corporation at its home office shall reinstate the contract, but with respect to sickness and injury, only to cover such sickness as may be first manifested more than 10 days after the date of such acceptance.

(d) In every such contract made, issued or delivered in this State:

(1) All printed portions shall be plainly printed;

(2) The exceptions from the contract shall appear with the same prominence as the benefits to which they apply; and

(3) If the contract contains any provision purporting to make any portion of the articles, constitution or bylaws of the corporation a part of the contract, such portion shall be set forth in full.

(e) A service corporation may issue a master group contract with the approval of the Commissioner if the contract and the individual certificates issued to members of the group comply in substance to the other provisions of this Article and Article 66 of this Chapter. The contract may provide for the adjustment of the rate of the premium or benefits conferred as provided in the contract, and in accordance with an adjustment schedule filed with and approved by the Commissioner. If the contract is issued, altered or modified, the subscribers' contracts issued under that contract are altered or modified accordingly, all laws and clauses in subscribers' contracts to the contrary notwithstanding. Nothing in this Article and Article 66 of this Chapter shall be construed to prohibit or prevent the same. Forms of such contract shall at all times be furnished upon request of subscribers thereto.

(e1) Employees shall be added to the master group coverage no later than 90 days after their first day of employment. Employment shall be considered continuous and not be considered broken except for unexcused absences from work for reasons other than illness or injury. The term "employee" is defined as a nonseasonal person who works on a full-time basis, with a normal work week of 30 or more hours and who is otherwise eligible for coverage, but does not include a person who works on a part-time, temporary, or substitute basis.

(e2) Whenever an employer master group contract replaces another group contract, whether this contract was issued by a corporation under Articles 1 through 67 of this Chapter, the liability of the succeeding corporation for insuring persons covered under the previous group contract is (i) each person is eligible for coverage in accordance with the succeeding corporation's plan of benefits with respect to classes eligible and activity at work and nonconfinement rules must be covered by the succeeding corporation's plan of benefits; and (ii) each person not covered under the succeeding corporation's plan of benefits in accordance with (i) above must nevertheless be covered by the succeeding corporation if that person was validly covered, including benefit extension, under the prior plan on the date of discontinuance and if the person is a member of the class of persons eligible for coverage under the succeeding corporation's plan.

(f) Any hospitalization contract renewed in the name of the subscriber during the grace period shall be construed to be a continuation of the contract first issued. (1941, c. 338, s. 7; 1947, c. 820, ss. 3, 4; 1955, c. 679, ss. 1-3; 1957, c. 1085, s. 1; 1961, c. 1149; 1989, c. 775, s. 4; 1991, c. 720, s. 38; 1993, c. 408, s. 4; c. 409, s. 24; 1995, c. 507, s. 23A.1(e); 1997-259, s. 17.)

Editor's Note. —
Session Laws 1995, c. 507, s. 1.1, provides that this act shall be known and cited as the Expansion and Capital Improvements Appropriations Act of 1995.

Session Laws 1995, c. 507, s. 28.12 is a severability clause.

Session Laws 1997-259, s. 25, provides: "Sections 1 through 18 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after July 1, 1997. Sections 19, 20, 21, 22, and 23 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after January 1, 1998. For the purposes of this act, renewal of a contract is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the contract."

Effect of Amendments. — The 1997 amendment, effective July 1, 1997, in subsection (e) deleted "hospital" preceding "service corporation may", substituted "if the" for "of Insurance provided such" preceding "contract and the", substituted "group comply" for "group shall comply" preceding "in substance to", substituted "The" for "Any such" preceding "contract may provide", substituted "the" for "said" preceding "contract, and in", substituted "Commissioner. If the contract is issued, altered or modified, the subscribers' contracts issued under that contract" for "Commissioner of Insurance. If such master group contract is issued, altered or modified, the subscribers' contracts issued in pursuance thereof" preceding "are altered or"; deleted subdivisions (e)(1) and (e)(2) concerning evidence of individual insurability and preexisting conditions; and redesignated former subdivisions (e)(3) and (e)(4) as subsections (e1) and (e2). For applicability, see Editor's note.

§ 58-65-90. No discrimination against the mentally ill and chemically dependent.

(a) Definitions. — As used in this section, the term:

(1) "Mental illness" has the same meaning as defined in G.S. 122C-3(21); and

(2) "Chemical dependency" has the same meaning as defined in G.S. 58-65-75

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders DSM-3-R or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) Coverage of Physical Illness. — No service corporation governed by this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

(1) Refuse to issue or deliver to that individual any individual or group subscriber contract in this State that affords

benefits or coverage for medical treatment or service for physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(b1) Coverage of Mental Illness. — A subscriber contract that covers both physical illness or injury and mental illness may not impose a lesser lifetime or annual dollar limitation on the mental health benefits than on the physical illness or injury benefits, subject to the following:

(1) A lifetime limit or annual limit may be made applicable to all benefits under the subscriber contract, without distinguishing the mental health benefits.

(2) If the subscriber contract contains lifetime limits only on selected physical illness or injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the subscriber contract, the service corporation may impose a lifetime limit on the mental health benefits that is based on a weighted average of the respective lifetime limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(3) If the subscriber contract contains annual limits only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the subscriber contract, the service corporation may impose an annual limit on the mental health benefits that is based on a weighted average of the respective annual limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(4) Except as otherwise provided in this section, the subscriber contract may distinguish between mental illness benefits and physical injury or illness benefits with respect to other terms of the subscriber contract, including coinsurance, limits on provider visits or days of coverage, and requirements relating to medical necessity.

(5) If the service corporation offers two or more benefit package options under a subscriber contract, each package must comply with this subsection.

(6) This subsection does not apply to a subscriber contract if the service corporation can demonstrate to the Commissioner that compliance will increase the cost of the subscriber contract by one percent (1%) or more.

(7) This subsection expires October 1, 2001, but the expiration does not affect services rendered before that date.

(c) Mental Illness or Chemical Dependency Coverage Not Required. — Nothing in this section requires a service corporation to offer coverage for mental illness or chemical dependency, except as provided in G.S. 58-65-75.

(d) Applicability. — Subsection (b1) of this section applies only to subscriber contracts covering more than 50 employees. The remainder of this section applies only to group contracts covering 20 or more employees. (1989, c. 369, s. 1; 1991, c. 720, s. 82; 1997-259, s. 22.)

Editor's Note. — Session Laws 1997-259, s. 25, provides: "Sections 1 through 18 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after July 1, 1997. Sections 19, 20, 21, 22, and 23 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after January 1, 1998. For the purposes of this act, renewal of a contract is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the contract."

Effect of Amendments. — The 1997 amendment, effective July 1, 1997, in subsection (a) added the subcatchline "Definitions"; in subsection (b) added the subcatchline "Coverage of Physical Illness", and deleted "hospital, medical, dental or health" preceding "service corporation"; in subdivision (b)(1) substituted "subscriber" for "hospital, dental, medical or health service" preceding "contract in this"; added subsection (b1); and rewrote subsections (c) and (d). For applicability, see Editor's note.

§ 58-65-91. Coverage for certain treatment of diabetes.

(a) Every insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and every preferred provider plan under G.S. 58-50-56 that is issued, renewed, or amended on or after October 1, 1997, shall provide coverage for medically appropriate and necessary services, including diabetes outpatient self-management training and educational services, and equipment, supplies, medications, and laboratory procedures used to treat diabetes. Diabetes outpatient self-management training and educational services shall be provided by a physician or a health care professional designated by the physician. The hospital or medical service plan shall determine who shall provide and be reimbursed for the diabetes outpatient self-management training and educational services. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to the diabetes coverage required under this section.

(b) For the purposes of this section, "physician" is a person licensed to practice in this State under Article 1 or Article 7 of Chapter 90 of the General Statutes. (1997-225, s. 2; 1997-519, s. 3.12.)

Editor's Note. — Session Laws 1997-225, s. 6, made this section effective June 26, 1997.

Session Laws 1997-225, s. 4, provides: "Nothing in this act shall apply to specified accident, specified disease, hospital indemnity, or long-term care health insurance policies."

Session Laws 1997-225, s. 5, provides: "The North Carolina Commission for Health Services shall develop voluntary standards or guidelines for diabetes outpatient self-management training and educational services based on clinical practice recommendations and guidelines established by the Center for Disease Control and the American Diabetes Association. These standards or guidelines are not subject to Article 2A of Chapter 150B of the General Statutes."

Effect of Amendments. — The 1997 amendment, effective January 1, 1998, substituted "benefit plan under G.S. 58-55-56" for "contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55" in subsection (a).

§ 58-65-92. Coverage for mammograms and pap smears.

(a) Every insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and every preferred provider benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1992, shall provide coverage for pap smears and for low-dose screening mammography. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the certificate or contract shall apply to coverage for pap smears and low-dose screening mammography.

(b) As used in this section, "low-dose screening mammography" means a radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography, including a physician's interpretation of the results of the procedure.

(c) Coverage for low-dose screening mammography shall be provided as follows:

(1) One or more mammograms a year, as recommended by a physician, for any woman who is at risk for breast cancer. For purposes of this subdivision, a woman is at risk for breast cancer if any one or more of the following is true:
  a. The woman has a personal history of breast cancer;
  b. The woman has a personal history of biopsy-proven benign breast disease;
  c. The woman's mother, sister, or daughter has or has had breast cancer; or
  d. The woman has not given birth prior to the age of 30;
(2) One baseline mammogram for any woman 35 through 39 years of age, inclusive;
(3) A mammogram every other year for any woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a physician; and
(4) A mammogram every year for any woman 50 years of age or older.

(d) Reimbursement for a mammogram authorized under this section shall be made only if the facility in which the mammogram was performed meets mammography accreditation standards. Mammography accreditation standards shall be those established by the North Carolina Medical Care Commission unless such standards are not in effect, in which case standards established by the United States Department of Health and Human Services for Medicare/Medicaid coverage of screening mammography shall apply until Medical Care Commission standards become effective. Facilities that do not meet required mammography accreditation standards shall so inform the patient or the patient's legally responsible person prior to performing the mammogram.

(e) Coverage for pap smears shall be provided for pap smears obtained once a year, or more frequently if recommended by a physician. Coverage shall include the examination, the laboratory fee, and the physician's interpretation of the laboratory results. When the screening pap smear accreditation standards adopted by the North Carolina Medical Care Commission become effective, reimbursement for laboratory fees shall be made only if the laboratory meets those standards. Facilities utilizing services of laboratories that do not meet accreditation standards for screening pap smears shall, prior to performing the pap smear examination, inform the patient or the patient's legally responsible person that such laboratory fees will not be covered. (1991, c. 490, s. 2; 1997-519, s. 3.6.)

Effect of Amendments. — The 1997 amendment, effective January 1, 1998, substituted "benefit plan under G.S. 58-55-56" for "contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55" in subsection (a).

§ 58-65-93. Coverage for prostate-specific antigen (PSA) tests.

(a) Every insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and every preferred provider benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1994, shall provide coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the certificate or contract shall apply to coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer.

(b) As used in this section, "prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer" means serological tests for determining the presence of prostate cytoplasmic protein (PSA) and the generation of antibodies to it, as a novel marker for prostatic disease.

(c) Coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer shall be provided when recommended by a physician. (1993, c. 269, s. 2; 1997-519, s. 3.7.)

Effect of Amendments. — The 1997 amendment, effective January 1, 1998, substituted "benefit plan under G.S. 58-55-56" for "contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55" in subsection (a).

§ 58-65-94. Coverage of certain prescribed drugs for cancer treatment.

(a) No insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and no preferred provider benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1994, and that provides coverage for prescribed drugs approved by the federal Food and Drug Administration for the treatment of certain types of cancer shall exclude coverage of any drug on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the federal Food and Drug Administration. The drug, however, must be approved by the federal Food and Drug Administration and must have been proven effective and accepted for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia:

(1) The American Medical Association Drug Evaluations;
(2) The American Hospital Formulary Service Drug Information; or
(3) The United States Pharmacopeia Drug Information.

(b) Notwithstanding subsection (a) of this section, coverage shall not be required for any experimental or investigational drugs or any drug that the federal Food and Drug Administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed.

(c) This section shall apply only to cancer drugs and nothing in this section shall be construed, expressly or by implication, to create, impair, alter, limit, notify, enlarge, abrogate, or prohibit reimbursement for drugs used in the treatment of any other disease or condition. (1993, c. 506, s. 4.2; 1997-519, s. 3.8.)

Effect of Amendments. — The 1997 amendment, effective January 1, 1998, substituted "benefit plan under G.S. 58-55-56" for "contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55" in subsection (a).

§ 58-65-96. Coverage for reconstructive breast surgery following mastectomy.

(a) Every insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and every preferred provider benefit plan under G.S. 58-50-56 that is issued, renewed, or amended on or after January 1, 1998, that provides coverage for mastectomy shall provide coverage for reconstructive breast surgery resulting from a mastectomy. The coverage shall include coverage for all stages and revisions of reconstructive breast surgery performed on a nondiseased breast to establish symmetry when reconstructive surgery on a diseased breast is performed. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for reconstructive breast surgery. Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction, subject to the approval of the treating physician.

(b) As used in this section, the following terms have the meanings indicated:
(1) "Mastectomy" means the surgical removal of all or part of a breast as a result of breast cancer or breast disease.
(2) "Reconstructive breast surgery" means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts, and includes reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple/areolar complex. "Reconstructive breast surgery" also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast.

(c) A policy, contract, or plan subject to this section shall not:
(1) Deny coverage described in subsection (a) of this section on the basis that the coverage is for cosmetic surgery;
(2) Deny to a woman eligibility or continued eligibility to enroll or to renew coverage under the terms of the contract, policy,

or plan, solely for the purpose of avoiding the requirements of this section;

(3) Provide monetary payments or rebates to a woman to encourage her to accept less than the minimum protections available under this section;

(4) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider provided care to an individual participant or beneficiary in accordance with this section; or

(5) Provide incentives, monetary or otherwise, to an attending provider to induce the provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section. (1997-312, s. 2; 1997-519, s. 3.10.)

Editor's Note. — Session Laws 1997-312, s. 7, made this section effective July 17, 1997.

Session Laws 1997-312, s. 6, provides: "Nothing in this act shall apply to specified accident, specified disease, hospital indemnity, or long-term care health insurance policies."

Effect of Amendments. — The 1997 amendment, effective January 1, 1998, substituted "benefit plan under G.S. 58-55-56" for "contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55" in subsection (a).

§ 58-65-105. Visitations and examinations.

The Commissioner of Insurance or any deputy or examiner or other person whom he may appoint shall have the power of visitations and examination into the affairs of any such corporation and free access to all the books, papers and documents that relate to the business of the corporation, and may summon and qualify witnesses under oath to examine its officers, agents, or employees or other persons in relation to the affairs, transactions and conditions of the corporation. (1941, c. 338, s. 10; 1995, c. 360, s. 2(l).)

Effect of Amendments. — The 1995 amendment, effective July 1, 1995, deleted "the actual expense of which shall be paid by the association so examined" from the end of the section.

§ 58-65-140: Repealed by Session Laws 1997-519, s. 3.16, effective January 1, 1998.

Editor's Note. — Section 58-65-140 referred to in subdivision (b)(1) has been repealed.

Cross References. — For present provisions regarding preferred providers, see § 58-50-56.

Part 2. Indemnification.

§ 58-65-166. Policy statement and definitions.

Editor's Note. — Session Laws 1995, c. 193, s. 67, contains a severability clause.

§ 58-65-172. Indemnification of officers, employees, and agents.

Unless a corporation's articles of incorporation provide otherwise:

(1) An officer of the corporation is entitled to mandatory indemnification under G.S. 58-65-168 and is entitled to apply for court-ordered indemnification under G.S. 58-65-170, in each case to the same extent as a director;

(2) The corporation may indemnify and advance expenses under this Part to an officer, employee, or agent of the corporation to the same extent as to a director; and

(3) A corporation may also indemnify and advance expenses to an officer, employee, or agent who is not a director to the extent, consistent with public policy, that may be provided by its articles of incorporation, bylaws, general or specific action of its board of directors, or contract. (1989 (Reg. Sess., 1990), c. 1071, s. 1; 1995, c. 193, s. 56.)

Editor's Note. — Session Laws 1995, c. 193, s. 67 contains a severability clause.

ARTICLE 66.

Hospital, Medical and Dental Service Corporation Readable Insurance Certificates Act.

§ 58-66-30. Filing requirements; duties of the Commissioner.

(a) No insurer may make, issue, amend or renew any certificate or contract after the dates specified in G.S. 58-66-35 for the applicable type of insurance unless the certificate is in compliance with the provisions of G.S. 58-66-20 and 58-66-25, and unless the certificate is filed with the Commissioner for this approval. The policy will be deemed approved 90 days after filing unless disapproved within the 90-day period. The Commissioner may not unreasonably withhold this approval. Any disapproval must be delivered to the insurer in writing and must state the grounds for disapproval. Any certificate filed with the Commissioner must be accompanied by a certified Flesch scale readability analysis and test score and by the insurer's certification that the policy is, in the insurer's judgment, readable based on the factors specified in G.S. 58-66-20 and 58-66-25.

(b) The Commissioner must disapprove any certificate covered by subsection (a) of this section if he finds that:

(1) It is not accompanied by a certified Flesch scale analysis readability score of 50 or more;

(2) It is not accompanied by the insurer's certification that the certificate is, in the judgment of the insurer, readable under the standards of this Article; or

(3) It does not comply with the format requirements of G.S. 58-66-20. (1979, 2nd Sess., c. 1161, s. 1; 1995, c. 193, s. 57.)

Editor's Note. — Session Laws 1995, c. 193, s. 67 contains a severability clause.

§ 58-66-35. Application to policies; dates.

(a) The filing requirements of G.S. 58-66-30 apply to all subscribers' contracts of hospital, medical, and dental service corporations as described in G.S. 58-65-60(a) and (b) that are made, issued, amended or renewed after July 1, 1983.

(b) Repealed by Session Laws 1995, c. 193, s. 58, effective June 7, 1995. (1979, 2nd Sess., c. 1161, s. 1; 1995, c. 193, s. 58; 1995 (Reg. Sess., 1996), c. 742, s. 28.)

Editor's Note. — Session Laws 1995, c. 193, s. 67, contains a severability clause.

This section is set out in the form above at the direction of the Revisor of Statutes.

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective June 21, 1996, deleted "duties of the Commissioner" from the end of the catchline.

ARTICLE 67.

Health Maintenance Organization Act.

§ 58-67-5. Definitions.

(a) "Commissioner" means the Commissioner of Insurance.

(b) "Enrollee" means an individual who is covered by an HMO.

(c) "Evidence of coverage" means any certificate, agreement, or contract issued to an enrollee setting out the coverage to which he is entitled.

(d) "Health care plan" means any arrangement whereby any person undertakes on a prepaid basis to provide, arrange for, pay for, or reimburse any part of the cost of any health care services and at least part of such arrangement consists of arranging for or the provision of health care services, as distinguished from mere indemnification against the cost of such services on a prepaid basis through insurance or otherwise.

(e) "Health care services" means any services included in the furnishing to any individual of medical or dental care, or hospitalization or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human illness or injury.

(f) "Health maintenance organization" or "HMO" means any person who undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis except for enrollee responsibility for copayments and deductibles. For the purposes of 11 U.S.C. § 109(b)(2) and (d), an HMO is a domestic insurance company.

(g) "Person" includes associations, trusts, or corporations, but does not include professional associations, or individuals.

(h) "Provider" means any physician, hospital, or other person that is licensed or otherwise authorized in this State to furnish health care services.

(i) "Net worth" means the excess of total assets over the total liabilities and may include borrowed funds that are repayable only from the net earned income of the health maintenance organization and repayable only with the advance permission of the Commissioner. For the purposes of this subsection, "assets" means (i) tangible assets and (ii) other investments permitted under G.S. 58-67-60; provided, however, that the depreciated cost of office furniture and equipment in the principal office shall not exceed ten percent (10%) of a health maintenance organization's net worth.

(j) "Working capital" means the excess of current assets over current liabilities; provided that the only borrowed funds that may be included in working capital must be those borrowed funds that are repayable only from net earned income and must be repayable only with the advance permission of the Commissioner.

(k) "Subscriber" means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the HMO; or in the case of an individual contract, the person in whose name the contract is issued.

(*l*) "Participating provider" means a provider who, under an express or implied contract with the HMO or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, directly or indirectly, from the HMO, other than copayment or deductible.

(m) "Insolvent" or "insolvency" means that the HMO has been declared insolvent and is placed under an order of liquidation by a court of competent jurisdiction.

(n) "Carrier" means an HMO, an insurer, a nonprofit hospital or medical service corporation, or other entity responsible for the payment of benefits or provision of services under a group contract.

(o) "Discontinuance" means the termination of the contract between the group contract holder and an HMO due to the insolvency of the HMO and does not mean the termination of any agreement between any individual enrollee and the HMO.

(p) "Uncovered expenditures" means the amounts owed or paid to any provider who provides health care services to an enrollee and where such amount owed or paid is (i) not made pursuant to a written contract that contains the "hold harmless" provisions defined in G.S. 58-67-115; or (ii) not guaranteed or insured by a guaranteeing organization or insurer under the terms of a written guarantee or insurance policy that has been determined to be acceptable to the Commissioner. "Uncovered expenditures" includes amounts owed or paid to providers directly from the HMO as well as payments made by a medical group, independent practice association, or any other similar organization to reimburse providers for services rendered to an enrollee. (1977, c. 580, s. 1; 1979, c. 876, s. 1; 1987, c. 631, s. 1; 1989, c. 776, ss. 2, 3, 15; 1991, c. 195, s. 4; c. 720, s. 40.)

Editor's Note. — This section has been set out in the supplement to correct a printing error.

§ 58-67-10. Establishment of health maintenance organizations.

(a) Notwithstanding any law of this State to the contrary, any person may apply to the Commissioner for a certificate of authority to establish and operate a health maintenance organization in compliance with this Article. No person shall establish or operate a health maintenance organization in this State, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health maintenance organization without obtaining a certificate of authority under this Article. A foreign corporation may qualify under this Article, subject to its full compliance with Article 16 of this Chapter.

(b)(1) It is specifically the intention of this section to permit such persons as were providing health services on a prepaid basis on July 1, 1977, or receiving federal funds under Section 254(c) of Title 42, U.S. Code, as a community health center, to continue to operate in the manner which they have heretofore operated.

(2) Notwithstanding anything contained in this Article to the contrary, any person can provide health services on a fee for service basis to individuals who are not enrollees of the organization, and to enrollees for services not covered by the contract, provided that the volume of services in this manner shall not be such as to affect the ability of the health maintenance organization to provide on an adequate and timely basis those services to its enrolled members which it has contracted to furnish under the enrollment contract.

(3) This Article shall not apply to any employee benefit plan to the extent that the Federal Employee Retirement Income Security Act of 1974 preempts State regulation thereof.

(3a) **(See note)** This Article does not apply to any prepaid health service or capitation arrangement implemented or administered by the Department of Health and Human Services or its representatives, pursuant to 42 U.S.C. § 1396n or Chapter 108A of the General Statutes, or to any provider of health care services participating in such a prepaid health service or capitation arrangement. Article; provided, however, that to the extent this Article applies to any such person acting as a subcontractor to a Health Maintenance Organization licensed in this State, that person shall be considered a single service Health Maintenance Organization for the purpose of G.S. 58-67-20(4), G.S. 58-67-25, and G.S. 58-67-110.

(4) Except as provided in paragraphs (1), (2), (3), and (3a) of this subsection, the persons to whom these paragraphs are applicable shall be required to comply with all provisions contained in this Article.

(c) Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the Commissioner, and shall be set forth or be accompanied by the following:

(1) A copy of the basic organizational document, if any, of the applicant such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

(2) A copy of the bylaws, rules and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(3) A list of the names, addresses, and official positions of persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association;

(4) A copy of any contract form made or to be made between any class of providers and the HMO and a copy of any contract form made or to be made between third party administrators, marketing consultants, or persons listed in subdivision (3) of this subsection and the HMO;

(5) A statement generally describing the health maintenance organization, its health care plan or plans, facilities, and personnel;

(6) A copy of the form of evidence of coverage to be issued to the enrollees;

(7) A copy of the form of the group contract, if any, which is to be issued to employers, unions, trustees, or other organizations;

(8) Financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent regular certified financial statement shall be deemed to satisfy this requirement unless the Commissioner directs that additional or more recent financial information is required for the proper administration of this Article;

(9) A financial feasibility plan, which includes detailed enrollment projections, the methodology for determining premium rates to be charged during the first 12 months of operations certified by an actuary or a recognized actuarial consultant, a projection of balance sheets, cash flow statements, showing any capital expenditures, purchase and sale of investments and deposits with the State, and income and expense statements anticipated from the start of operations until the organization has had net income for at least one year; and a statement as to the sources of working capital as well as any other sources of funding;

(10) A power of attorney duly executed by such applicant, if not domiciled in this State, appointing the Commissioner and his successors in office, and duly authorized deputies, as the true and lawful attorney of such applicant in and for this State upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this State may be served;

(11) A statement reasonably describing the geographic area or areas to be served;

(12) A description of the procedures to be implemented to meet the protection against insolvency requirements of G.S. 58-67-110;

(13) A description of the internal grievance procedures to be utilized for the investigation and resolution of enrollee complaints and grievances; and

(14) Such other information as the Commissioner may require to make the determinations required in G.S. 58-67-20.

(d)(1) A health maintenance organization shall file a notice describing any significant modification of the operation set out in the information required by subsection (c) of this section. Such notice shall be filed with the Commissioner prior to the modification. If the Commissioner does not disapprove within 90 days after the filing, such modification shall be deemed to be approved. Changes subject to the terms of this section include expansion of service area, changes in provider contract forms and group contract forms where the distribution of risk is significantly changed, and any other changes that the Commissioner describes in properly promulgated rules. Every HMO shall report to the Commissioner for his information material changes in the provider network, the addition or deletion of Medicare risk or Medicaid risk arrangements and the addition or deletion of employer groups that exceed ten percent (10%) of the health maintenance organization's book of business or such other information as the Commissioner may require. Such information shall be filed with the Commissioner within 15 days after implementation of the reported changes. Every HMO shall file with the Commissioner all subsequent changes in the information or forms that are required by this Article to be filed with the Commissioner.

(2) The Commissioner may promulgate rules and regulations exempting from the filing requirements of subdivision (1) those items he deems unnecessary. (1977, c. 580, s. 1; 1979, c. 876, s. 1; 1983, c. 386, s. 1; 1985 (Reg. Sess., 1986), c. 1027, s. 49; 1987, c. 631, ss. 6, 7; 1989, c. 776, ss. 4-8; 1991, c. 720, ss. 41, 69; 1993, c. 529, s. 7.2; 1993 (Reg. Sess., 1994), c. 769, s. 25.48; 1997-443, s. 11A.118(a).)

Editor's Note. — Session Laws 1997-443, s. 1.1, provides: "This act shall be known as 'The Current Operations and Capital Improvements Appropriations Act of 1997'".

Session Laws 1997-443, s. 35.4, is a severability clause.

Effect of Amendments. — The 1997 amendment, effective August 28, 1997, substituted "Health and Human Services" for "Human Resources."

§ 58-67-11. Additional HMO application information.

(a) In addition to the information filed under G.S. 58-67-10(c), each application shall include a description of the following:

(1) The program to be used to evaluate whether the applicant's provider network is sufficient, in numbers and types of providers, to assure that all health care services will be accessible without unreasonable delay.

(2) The program to be used for verifying provider credentials.

(3) The quality management program to assure quality of care and health care services managed and provided through the health care plan.

(4) The utilization review program for the review and control of health care services provided or paid for.

(5) The applicant's provider network and evidence of the ability of that network to provide all health care services to the applicant's prospective enrollees.

(b) G.S. 58-67-10(d) applies to the information specified in this section. (1997-519, s. 1.2.)

Editor's Note. — Session Laws 1997-519, s. 5, made this section effective January 1, 1998.

§§ 58-67-12 through 58-67-14: Reserved for future codification purposes.

§ 58-67-35. Powers of health maintenance organizations.

(a) The powers of a health maintenance organization include, but are not limited to the following:

(1) The purchase, lease, construction, renovation, operation, or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and such property as may reasonably be required for its principal office or for such other purposes as may be necessary in the transaction of the business of the organization;

(2) The making of loans to a medical group under contract with it in furtherance of its program or the making of loans to a corporation or corporations under its control for the purpose of acquiring or constructing medical facilities and hospitals or in furtherance of a program providing health care services to enrollees;

(3) The furnishing of health care services through providers which are under contract with or employed by the health maintenance organization;

(4) The contracting with any person for the performance on its behalf of certain functions such as marketing, enrollment and administration;

(5) The contracting with an insurance company licensed in this State, or with a hospital or medical service corporation authorized to do business in this State, for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the health maintenance organization;

(6) The offering and contracting for the provision or arranging of, in addition to health care services, of:
  a. Additional health care services;
  b. Indemnity benefits, covering out-of-area or emergency services;
  c. Indemnity benefits, in addition to those relating to out-of-area and emergency services, provided through insurers or hospital or medical service corporations; and
  d. Point-of-service products, for which the Commissioner shall adopt rules governing:
    1. The percentage of an HMO's total health care expenditures for out-of-plan covered services for all of its members that may be spent on those services, which may not exceed twenty percent (20%);
    2. Product limitations, which may provide for payment differentials for services rendered by providers

who are not in an HMO network, subject to G.S. 58-3-200(d).
3. Deposit and other financial requirements; and
4. Other requirements for marketing and administering those products.

(b)(1) A health maintenance organization shall file notice, with adequate supporting information, with the Commissioner prior to the exercise of any power granted in subsections (a)(1) or (2). The Commissioner shall disapprove such exercise of power if in his opinion it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. If the Commissioner does not disapprove within 30 days of the filing, it shall be deemed approved.

(2) The Commissioner may promulgate rules and regulations exempting from the filing requirement of subdivision (1) those activities having a de minimis effect. (1977, c. 580, s. 1; 1979, c. 876, s. 1; 1991 (Reg. Sess., 1992), c. 837, s. 8; 1997-519, s. 3.18.)

Effect of Amendments. — The 1997 amendment, effective January 1, 1998, added "which may provide for payment differentials for services rendered by providers who are not in an HMO network, subject to G.S. 58-3-200(d)" at the end of subdivision (a)(6)d.2.

§ 58-67-50. Evidence of coverage and premiums for health care services.

(a)(1) Every enrollee residing in this State is entitled to evidence of coverage under a health care plan. If the enrollee obtains coverage under a health care plan through an insurance policy or a contract issued by a hospital or medical service corporation, whether by option or otherwise, the insurer or the hospital or medical service corporation shall issue the evidence of coverage. Otherwise, the health maintenance organization shall issue the evidence of coverage.

(2) No evidence of coverage, or amendment thereto, shall be issued or delivered to any person in this State until a copy of the form of the evidence of coverage, or amendment thereto, has been filed with and approved by the Commissioner.

(3) An evidence of coverage shall contain:
a. No provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, which encourage misrepresentation, or which are untrue, misleading or deceptive as defined in G.S. 58-67-65(a); and
b. A clear and complete statement, if a contract, or a reasonably complete summary, if a certificate of:
1. The health care services and insurance or other benefits, if any, to which the enrollee is entitled under the health care plan;
2. Any limitations on the services, benefits, or kind of benefits, to be provided, including any deductible or copayment feature;
3. Where and in what manner information is available as to how services may be obtained;

4. The total amount of payment for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay with respect to individual contracts, or an indication whether the plan is contributory or noncontributory with respect to group certificates;
5. A clear and understandable description of the health maintenance organization's method of resolving enrollee complaints;
6. A description of the reasons, if any, for which an enrollee's enrollment may be terminated for cause, which reasons may include behavior that seriously impairs the health maintenance organization's ability to provide services or an inability to establish and maintain a satisfactory physician-patient relationship after reasonable efforts to do so have been made.

Any subsequent change may be evidenced in a separate document issued to the enrollee.

(4) A copy of the form of the evidence of coverage to be used in this State, and any amendment thereto, shall be subject to the filing and approval requirements of subsection (b) unless it is subject to the jurisdiction of the Commissioner under the laws governing health insurance or hospital or medical service corporations in which event the filing and approval provisions of such laws shall apply. To the extent, however, that such provisions do not apply the requirements in subsection (c) shall be applicable.

(b)(1) No schedule of premiums for enrollee coverage for health care services, or amendment thereto, may be used in conjunction with any health care plan until a copy of such schedule, or amendment thereto, has been filed with and approved by the Commissioner.

(2) Such premiums may be established in accordance with actuarial principles for various categories of enrollees, provided that premiums applicable to an enrollee shall not be individually determined based on the status of his health. However, the premiums shall not be excessive, inadequate, or unfairly discriminatory; and must exhibit a reasonable relationship to the benefits provided by the evidence of coverage. Such premiums or any revisions thereto with respect to nongroup enrollee coverage shall be guaranteed, as to every enrollee covered under the same category of enrollee coverage, for a period of not less than 12 months; or as an alternative to giving such guarantee with respect only to nongroup enrollee coverage, such premium or premium revisions may be made applicable to all similar category of enrollee coverage at one time if the health maintenance organization chooses to apply for such premium revision with respect to such categories of coverages no more frequently than once in any 12-month period. Such premium revision shall be applicable to all categories of nongroup enrollee coverage of the same type; provided that no premium revision may become effective for any category of enrollee coverage unless the corporation has given written notice of the premium revision 45 days prior

to the effective date of such revision. The enrollee thereafter must pay the revised premium in order to continue the contract in force. The Commissioner may promulgate reasonable rules, after notice and hearing, to require the submission of supporting data and such information as is deemed necessary to determine whether such rate revisions meet these standards.

(c) The Commissioner shall, within a reasonable period, approve any form if the requirements of subsection (a) of this section are met and any schedule of premiums if the requirements of subsection (b) of this section are met. It shall be unlawful to issue the form or to use the schedule of premiums until approved. If the Commissioner disapproves the filing, the Commissioner shall notify the filer. In the notice, the Commissioner shall specify the reasons for disapproval. A hearing will be granted within 30 days after a request in writing by the person filing. If the Commissioner does not approve or disapprove any form or schedule of premiums within 90 days after the filing for forms and within 45 days after the filing for premiums, they shall be deemed to be approved.

(d) The Commissioner may require the submission of whatever relevant information he deems necessary in determining whether to approve or disapprove a filing made pursuant to this section.

(e) Effective January 1, 1989, every health maintenance organization shall provide at least minimum cost and utilization information for group contracts of 100 or more subscribers on an annual basis when requested by the group. Such information shall be compiled in accordance with the Data Collection Form developed by the Standardized HMO Date Form Task Force as endorsed by the Washington Business Group on Health and the Group Health Association of America on November 19, 1986, and any subsequent amendments. In addition, beginning with data for the calendar year 1998, every HMO, for group contracts of 1,000 or more members, shall provide cost, use of service, prevention, outcomes, and other group-specific data as collected in accordance with the latest edition of the Health Plan Employer Data and Information Set (HEDIS) guidelines, as published by the National Committee for Quality Assurance. Beginning with data for the calendar year 1998, every HMO shall file with the Commissioner and make available to all employer groups, not later than July 1 of the following calendar year, a report of health benefit plan-wide experience on its costs, use of services, and other aspects of performance, in the HEDIS format. (1977, c. 580, s. 1; 1979, c. 876, s. 1; 1987, c. 631, s. 9; 1989, c. 485, s. 59; 1991, c. 195, s. 1; c. 644, s. 13; c. 720, s. 36; 1995, c. 193, s. 59; 1997-474, s. 3; 1997-519, s. 1.3.)

Editor's Note. — Session Laws 1995, c. 193, s. 67 contains a severability clause.

Effect of Amendments. — Session Laws 1997-474, s. 3, effective September 3, 1997, substituted "45 days" for "60 days" in the last sentence of subsection (c).

Session Laws 1997-519, s. 1.3, effective January 1, 1998, deleted "on" following "Effective" at the beginning of subsection (e), and added the last two sentences of that subsection.

§ 58-67-66. Collaboration with local health departments.

A health maintenance organization and a local health department shall collaborate and cooperate within available resources regarding health promotion and disease prevention efforts that are necessary to protect the public health. (1997-474, s. 4.)

Editor's Note. — Session Laws 1997-474, s. 5, made this section effective September 3, 1997.

§ 58-67-74. Coverage for certain treatment of diabetes.

(a) Every health care plan written by a health maintenance organization and in force, issued, renewed, or amended on or after October 1, 1997, that is subject to this Article, shall provide coverage for medically appropriate and necessary services, including diabetes outpatient self-management training and educational services, and equipment, supplies, medications, and laboratory procedures used to treat diabetes. Diabetes outpatient self-management training and educational services shall be provided by a physician or a health care professional designated by the physician. The health maintenance organization shall determine who shall provide and be reimbursed for the diabetes outpatient self-management training and educational services. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to the diabetes coverage required under this section.

(b) For the purposes of this section, "physician" is a person licensed to practice in this State under Article 1 or Article 7 of Chapter 90 of the General Statutes. (1997-225, s. 3.)

Editor's Note. — Session Laws 1997-225, s. 6, made this section effective June 26, 1997.

Session Laws 1997-225, s. 4, provides: "Nothing in this act shall apply to specified accident, specified disease, hospital indemnity, or long-term care health insurance policies."

Session Laws 1997-225, s. 5, provides: "The North Carolina Commission for Health Services shall develop voluntary standards or guidelines for diabetes outpatient self-management training and educational services based on clinical practice recommendations and guidelines established by the Center for Disease Control and the American Diabetes Association. These standards or guidelines are not subject to Article 2A of Chapter 150B of the General Statutes."

§ 58-67-75. No discrimination against the mentally ill and chemically dependent.

(a) Definitions. — As used in this section, the term:

(1) "Mental illness" has the same meaning as defined in G.S. 122C-3(21); and
(2) "Chemical dependency" has the same meaning as defined in G.S. 58-67-70

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders DSM-3-R or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) Coverage of Physical Illness. — No health maintenance organization governed by this Chapter shall, solely because an individual has or had a mental illness or chemical dependency:

(1) Refuse to enroll that individual in any health care plan covering physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(b1) Coverage of Mental Illness. — A health care plan that covers both physical illness or injury and mental illness may not impose a lesser lifetime or annual dollar limitation on the mental health benefits than on the physical illness or injury benefits, subject to the following:

(1) A lifetime limit or annual limit may be made applicable to all benefits under the plan, without distinguishing the mental health benefits.

(2) If the plan contains lifetime limits only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the plan, the HMO may impose a lifetime limit on the mental health benefits that is based on a weighted average of the respective lifetime limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(3) If the plan contains annual limits only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the plan, the HMO may impose an annual limit on the mental health benefits that is based on a weighted average of the respective annual limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(4) Except as otherwise provided in this section, the plan may distinguish between mental illness benefits and physical injury or illness benefits with respect to other terms of the plan, including coinsurance, limits on provider visits or days of coverage, and requirements relating to medical necessity.

(5) If the HMO offers two or more benefit package options under a plan, each package must comply with this subsection.

(6) This subsection does not apply to a health benefit plan if the HMO can demonstrate to the Commissioner that compliance will increase the cost of the plan by one percent (1%) or more.

(7) This subsection expires October 1, 2001, but the expiration does not affect services rendered before that date.

(c) Mental Illness or Chemical Dependency Coverage Not Required. — Nothing in this section requires an HMO to offer coverage for mental illness or chemical dependency, except as provided in G.S. 58-67-70.

(d) Applicability. — Subsection (b1) of this section applies only to group contracts covering more than 50 employees. The remainder of this section applies only to group contracts covering 20 or more employees. (1989, c. 369, s. 2; 1991, c. 720, s. 83; 1997-259, s. 23.)

Editor's Note. — Session Laws 1997-259, s. 25, provides: "Sections 1 through 18 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after July 1, 1997. Sections 19, 20, 21, 22, and 23 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after January 1, 1998. For the purposes of this act, renewal of a contract is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the contract."

Effect of Amendments. — The 1997 amendment, effective July 1, 1997, in subsection (a) added the subcatchline "Definitions"; in subsection (b) added the subcatchline "Coverage of Physical Illness"; added subsection (b1); and rewrote subsections (c) and (d). For applicability, see Editor's Note.

§ 58-67-79. Coverage for reconstructive breast surgery following mastectomy.

(a) Every health care plan written by a health maintenance organization and in force, issued, renewed, or amended on or after January 1, 1998, that is subject to this Article and that provides coverage for mastectomy shall provide coverage for reconstructive breast surgery resulting from a mastectomy. The coverage shall include coverage for all stages and revisions of reconstructive breast surgery performed on a nondiseased breast to establish symmetry when reconstructive surgery on a diseased breast is performed. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for reconstructive breast surgery. Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction, subject to the approval of the treating physician.

(b) As used in this section, the following terms have the meanings indicated:

(1) "Mastectomy" means the surgical removal of all or part of a breast as a result of breast cancer or breast disease.

(2) "Reconstructive breast surgery" means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts, and includes reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple/areolar complex. "Reconstructive breast surgery" also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast.

(c) A policy, contract, or plan subject to this section shall not:

(1) Deny coverage described in subsection (a) of this section on the basis that the coverage is for cosmetic surgery;

(2) Deny to a woman eligibility or continued eligibility to enroll or to renew coverage under the terms of the contract, policy, or plan, solely for the purpose of avoiding the requirements of this section;

(3) Provide monetary payments or rebates to a woman to encourage her to accept less than the minimum protections available under this section;

(4) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider provided care to

an individual participant or beneficiary in accordance with this section; or

(5) Provide incentives, monetary or otherwise, to an attending provider to induce the provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section. (1997-312, s. 3.)

Editor's Note. — Session Laws 1997-312, s. 7, made this section effective July 17, 1997.

Session Laws 1997-312, s. 6, provides: "Nothing in this act shall apply to specified accident, specified disease, hospital indemnity, or long-term care health insurance policies."

§ 58-67-85. Master group contracts, filing requirement; required and prohibited provisions.

(a) A health maintenance organization may issue a master group contract with the approval of the Commissioner of Insurance provided the contract and the individual certificates issued to members of the group, shall comply in substance to the other provisions of this Article. Any such contract may provide for the adjustment of the rate of the premium or benefits conferred as provided in the contract, and in accordance with an adjustment schedule filed with and approved by the Commissioner of Insurance. If the master group contract is issued, altered or modified, the enrollees' contracts issued in pursuance thereof are altered or modified accordingly, all laws and clauses in the enrollees" contracts to the contrary notwithstanding. Nothing in this Article shall be construed to prohibit or prevent the same. Forms of such contract shall at all times be furnished upon request of enrollees thereto.

(b), (c) Repealed by Session Laws 1997-259, s. 18, effective July 1, 1997.

(d) Employees shall be added to the master group coverage no later than 90 days after their first day of employment. Employment shall be considered continuous and not be considered broken except for unexcused absences from work for reasons other than illness or injury. The term "employee" is defined as a nonseasonal person who works on a full-time basis, with a normal work week of 30 or more hours and who is otherwise eligible for coverage, but does not include a person who works on a part-time, temporary, or substitute basis.

(e) Whenever an employer master group contract replaces another group contract, whether the contract was issued by a corporation under Articles 1 through 67 of this Chapter, the liability of the succeeding corporation for insuring persons covered under the previous group contract is:

(1) Each person who is eligible for coverage in accordance with the succeeding corporation's plan of benefits with respect to classes eligible and activity at work and nonconfinement rules must be covered by the succeeding corporation's plan of benefits; and

(2) Each person not covered under the succeeding corporation's plan of benefits in accordance with (e)(1) must nevertheless be covered by the succeeding corporation if that person was validly covered, including benefit extension, under the prior plan on the date of discontinuance and if the person is a

member of the class of persons eligible for coverage under the succeeding corporation's plan. (1989, c. 775, s. 5; 1991, c. 720, s. 38; 1993, c. 408, ss. 5, 5.1; 1995, c. 507, s. 23A.1(f); 1997-259, s. 18.)

Editor's Note. —

Session Laws 1995, c. 507, s. 1.1, provides that this act shall be known and cited as the Expansion and Capital Improvements Appropriations Act of 1995.

Session Laws 1995, c. 507, s. 28.12 is a severability clause.

Session Laws 1997-259, s. 25, provides: "Sections 1 through 18 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after July 1, 1997. Sections 19, 20, 21, 22, and 23 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after January 1, 1998. For the purposes of this act, renewal of a contract is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the contract."

Effect of Amendments. — The 1997 amendment, effective July 1, 1997, deleted subsections (b) and (c), concerning evidence of individual insurability and preexisting conditions. For applicability, see Editor's Note.

§ 58-67-100. Examinations.

(a) The Commissioner may make an examination of the affairs of any health maintenance organization and the contracts, agreements or other arrangements pursuant to its health care plan as often as the Commissioner deems it necessary for the protection of the interests of the people of this State but not less frequently than once every three years. Examinations shall otherwise be conducted under G.S. 58-2-131, 58-2-132, and 58-2-133.

(b) Repealed by Session Laws 1997-519, s. 1, effective January 1, 1998.

(c) Repealed by Session Laws 1995, c. 360, s. 2(m).

(d) Instead of conducting an examination, the Commissioner may accept the report of an examination made by the HMO regulator of another state. (1977, c. 580, s. 1; 1979, c. 876, s. 1; 1995, c. 360, s. 2(m); 1997-519, s. 1.4.)

Effect of Amendments. — The 1997 amendment, effective January 1, 1998, substituted "the Commissioner" for "he" in the first sentence of subsection (a), added the second sentence of subsection (a), deleted subsection (b), relating to the submission of health maintenance organizations' books and records to examination, and substituted "Instead of conducting an" for "In lieu of such" and "HMO regulator" for "Commissioner of Insurance or Commissioner of Public Health" in subsection (d).

§ 58-67-140. Suspension or revocation of license.

(a) The Commissioner may suspend, revoke, or refuse to renew an HMO license if the Commissioner finds that the HMO:

(1) Is operating significantly in contravention of its basic organizational document, or in a manner contrary to that described in and reasonably inferred from any other information submitted under G.S. 58-67-10, unless amendments to such submissions have been filed with and approved by the Commissioner.

(2) Issues evidences of coverage or uses a schedule of premiums for health care services that do not comply with G.S. 58-67-50.

(3) No longer maintains the financial reserve specified in G.S. 58-67-40 or is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.
(4) Has itself or through any person on its behalf advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner.
(5) Is operating in a manner that would be hazardous to its enrollees.
(6) Knowingly or repeatedly fails or refuses to comply with any law or rule applicable to the HMO or with any order issued by the Commissioner after notice and opportunity for a hearing.
(7) Has knowingly published or made to the Department or to the public any false statement or report, including any report or any data that serves as the basis for any report, required to be submitted under G.S. 58-3-210.

(b) A license shall be suspended or revoked only after compliance with G.S. 58-67-155.

(c) When an HMO license is suspended, the HMO shall not, during the suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation.

(d) When an HMO license is revoked, the HMO shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the HMO. The HMO shall engage in no advertising or solicitation. The Commissioner may, by written order, permit such further operation of the HMO as the Commissioner may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage. (1977, c. 580, s. 1; 1979, c. 876, s. 1; 1997-519, s. 1.5.)

Effect of Amendments. — The 1997 amendment, effective January 1, 1998, substituted "license" for "certificate of authority" in the section catchline, and rewrote the section.

§ 58-67-160. Fees.

Editor's Note. —

Session Laws 1995, c. 507, s. 11A(c), amended Session Laws 1989 (Reg. Sess., 1990), c. 1069, s. 31, deleting the last sentence regarding the expiration of amendments to the General Statutes by Session Laws 1989 (Reg. Sess., 1990), c. 1069, if the legislature did not appropriate or transfer funds. Session Laws 1989 (Reg. Sess., 1990), s. 31, as amended by Session Laws 1995, c. 507, s. 11A(c), provides: "Section 23 [see § 58-36-70] of this act does not apply to the 1990 automobile rate filing made pursuant to Article 36 of Chapter 58 of the General Statutes. Section 27 [§ 143-3.6] of this act shall expire at the end of the 1993-1994 fiscal year and Section 28 [§ 143-3.7] shall become effective upon the expiration of Section 27."

Session Laws 1995, c. 507, s. 1.1, provides that this act shall be known and cited as the Expansion and Capital Improvements Appropriations Act of 1995.

Session Laws 1995, c. 507, s. 28.9, provides: "Except for statutory changes or other provisions that clearly indicate an intention to have effects beyond the 1995-97 fiscal biennium, the textual provisions of this act apply only to funds appropriated for, and activities occurring during, the 1995-97 biennium."

ARTICLE 68.

Health Insurance Portability and Accountability.

§§ 58-68-1 through 58-68-20: Repealed by Session Laws 1997-259, s. 1(a), effective July 1, 1997.

Part A. Group Market Reforms.

1. Portability, Access, and Renewability Requirements.

§ 58-68-25. Definitions; excepted benefits; employer size rule.

(a) Definitions. — In addition to other definitions throughout this Article, the following definitions and their cognates apply in this Article:

(1) "Bona fide association". — With respect to health insurance coverage offered in this State, an association that:
  a. Has been actively in existence for at least five years.
  b. Has been formed and maintained in good faith for purposes other than obtaining insurance.
  c. Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee).
  d. Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members (or individuals eligible for coverage through a member).
  e. Does not make health insurance coverage offered through the association available other than in connection with a member of the association.
  f. Meets the additional requirements as may be imposed under State law.

(2) "COBRA continuation provision". — Any of the following:
  a. Section 4980B of the Internal Revenue Code of 1986, other than subdivision (f)(1) of the section insofar as it relates to pediatric vaccines.
  b. Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, other than section 609 of the Act.
  c. Title XXII of the Public Health Service Act (42 U.S.C.S. § 300bb, et seq.,) as requirements for certain group health plans for certain State and local employees.
  d. Article 53 of this Chapter or the health insurance continuation law of another state.

(3) "Employee". — The meaning given the term under section 3(6) of the Employee Retirement Income Security Act of 1974.

(4) "Employer". — The meaning given the term under section 3(5) of the Employee Retirement Income Security Act of

1974, except that the term shall include only employers of two or more employees.

(5) "Health insurance coverage" or "coverage" or "health insurance plan" or "plan". — Benefits consisting of medical care, provided directly through insurance or otherwise and including items and services paid for as medical care, under any accident and health insurance policy or certificate, hospital or medical service plan contract, or health maintenance organization contract, written by a health insurer.

(6) "Health insurer". — An insurance company subject to this Chapter, a hospital or medical service corporation subject to Article 65 of this Chapter, a health maintenance organization subject to Article 67 of this Chapter, or a multiple employer welfare arrangement subject to Article 49 of this Chapter, that offers and issues health insurance coverage.

(7) "Health status-related factor". — Any of the factors described in G.S. 58-68-35(a)(1).

(8) "Individual health insurance coverage". — Health insurance coverage offered to individuals in the individual market, but not short-term limited duration insurance.

(9) "Individual market". — The market for health insurance coverage offered to individuals.

(10) "Large employer". — An employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the health insurance plan year.

(11) "Large group market". — The health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health insurance plan maintained by a large employer.

(12) "Medical care". — Amounts paid for:

a. The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body.

b. Amounts paid for transportation primarily for and essential to medical care referred to in sub-subdivision a. of this subdivision.

c. Amounts paid for insurance covering medical care referred to in sub-subdivisions a. and b. of this subdivision.

(13) "Network plan". — Health insurance coverage of a health insurer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of health care providers under contract with the health insurer.

(14) "Participant". — The meaning given the term under section 3(7) of the Employee Retirement Income Security Act of 1974.

(15) "Placed for adoption". — The assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with the person terminates upon the termination of the legal obligation.

(16) "Small employer". — The meaning given to the term in G.S. 58-50-110(22).

(17) "Small group market". — The health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health insurance plan maintained by a small employer.

(b) Excepted Benefits. — For the purposes of this Article, "excepted benefits" means benefits under one or more or any combination of the following:

(1) Benefits not subject to requirements. —
  a. Coverage only for accident or disability income insurance or any combination of these.
  b. Coverage issued as a supplement to liability insurance.
  c. Liability insurance, including general liability insurance and automobile liability insurance.
  d. Workers" compensation or similar insurance.
  e. Automobile medical payment insurance.
  f. Credit-only insurance.
  g. Coverage for on-site medical clinics.
  h. Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(2) Benefits not subject to requirements if offered separately. —
  a. Limited scope dental or vision benefits.
  b. Benefits for long-term care, nursing care, home health care, community-based care, or any combination of these.
  c. The other similar, limited benefits as are specified in federal regulations.

(3) Benefits not subject to requirements if offered as independent, noncoordinated benefits. —
  a. Coverage only for a specified disease or illness.
  b. Hospital indemnity or other fixed indemnity insurance.

(4) Benefits not subject to requirements if offered as separate insurance policy. — Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health insurance plan.

(c) Application of certain rules in determination of employer size. — For the purposes of this Article:

(1) Application of aggregation rule for employers. — All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer.

(2) Employers not in existence in preceding year. — In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

(3) Predecessors. — Any reference in this subsection to an employer shall include a reference to any predecessor of the employer. (1997-259, s. 1(c).)

Editor's Note. — Session Laws 1997-259, s. 26, made this Part effective July 1, 1997.

Session Laws 1997-259, s. 25, provides: "Sections 1 through 18 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after July 1, 1997. Sections 19, 20, 21, 22, and 23 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after January 1, 1998. For the purposes of this act, renewal of a contract is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the contract."

Effect of Amendments. — The 1997 amendment, effective July 1, 1997, substituted "Health Insurance Portability and Accountability" for "North Carolina Health Insurance Trust Commission" as the Article heading. For applicability, see Editor's note.

§ 58-68-30. Increased portability through limitation on preexisting condition exclusions.

(a) Limitation on Preexisting Condition Exclusion Period; Crediting for Periods of Previous Coverage. — Subject to subsection (d) of this section, a group health insurer may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if:

(1) The exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date.

(2) The exclusion extends for a period of not more than 12 months, or 18 months in the case of a late enrollee, after the enrollment date.

(3) The period of any preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage, if any, applicable to the participant or beneficiary as of the enrollment date.

(b) Definitions. — For the purposes of this Part:

(1) Enrollment date. — With respect to an individual covered under a group health insurance plan, the date of enrollment of the individual in the coverage or, if earlier, the first day of the waiting period for the enrollment.

(2) Late enrollee. — With respect to coverage under a group health insurance plan, a participant or beneficiary who enrolls under the plan other than during:

a. The first period in which the individual is eligible to enroll under the plan, or

b. A special enrollment period under subsection (f) of this section.

(3) Preexisting condition exclusion. —

a. In general. — "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for the coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before the date.

b. Treatment of genetic information. — Genetic information shall not be treated as a condition described in subdivision (a)(1) of this subsection in the absence of a diagnosis of the condition related to the information.

(4) Waiting period. — With respect to a group health insurance plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

(c) Rules Relating to Crediting Previous Coverage. —

(1) Creditable coverage defined. — For the purposes of this Article, "creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

a. A self-funded employer group health plan under the Employee Retirement Income Security Act of 1974.
b. Group or individual health insurance coverage.
c. Part A or part B of title XVIII of the Social Security Act.
d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928.
e. Chapter 55 of title 10, United States Code.
f. A medical care program of the Indian Health Service or of a tribal organization.
g. A State health benefits risk pool.
h. A health plan offered under chapter 89 of title 5, United States Code.
i. A public health plan (as defined in federal regulations).
j. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. § 2504(e)).

"Creditable coverage" does not include coverage consisting solely of coverage of excepted benefits.

(2) Not counting periods before significant breaks in coverage. —

a. In general. — A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health insurance plan, if, after the period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

b. Waiting period not treated as a break in coverage. — For the purposes of sub-subdivision a. of this subdivision and subdivision (d)(4) of this subsection, any period that an individual is in a waiting period for any coverage under a group health insurance plan or is in an affiliation period shall not be taken into account in determining the continuous period under sub-subdivision a. of this subdivision.

c. Time spent on short term limited duration health insurance not treated as a break in coverage. — For the purposes of sub-subdivision a. of this subdivision, any period that an individual is enrolled on a short term limited duration health insurance policy shall not be taken into account in determining the continuous period under sub-subdivision. a. of this subdivision so long as the period of time spent on the short term limited duration health insurance policy or policies does not exceed 12 months.

(3) Method of crediting coverage. —

a. Standard method. — Except as otherwise provided under sub-subdivision b. of this subdivision for the purposes of applying subdivision (a)(3) of this subsection, a group health insurer shall count a period of creditable coverage without regard to the specific benefits covered during the period.

b. Election of alternative method. — A group health insurer may elect to apply subdivision (a)(3) of this subsection based on coverage of benefits within each of several classes or categories of benefits specified in federal regulations rather than as provided under sub-subdivision a. of this subdivision. This election shall be made on a uniform basis for all participants and beneficiaries. Under this election a group health insurer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category.

c. Health insurer notice. — In the case of an election under sub-subdivision b. of this subdivision with respect to health insurance coverage in the small or large group market, the health insurer: (i) shall prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the health insurer has made the election, and (ii) shall include in the statements a description of the effect of the election.

(4) Establishment of period. — Periods of creditable coverage for an individual shall be established through presentation of certifications described in subsection (e) of this section or in another manner that is specified in federal regulations.

(d) Exceptions. —

(1) Exclusion not applicable to certain newborns. — Subject to subdivision (4) of this subsection, a group health insurer shall not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the individual's date of birth, is covered under creditable coverage.

(2) Exclusion not applicable to certain adopted children. — Subject to subdivision (4) of this subsection, a group health insurer shall not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence does not apply to coverage before the date of the adoption or placement for adoption.

(3) Exclusion not applicable to pregnancy. — A group health insurer shall not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(4) Loss if break in coverage. — Subdivisions (1) and (2) of this subsection shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

(e) Certifications and Disclosure of Coverage. —

(1) Requirement for certification of period of creditable coverage. —

a. In general. — A group health insurer shall provide the certification described in sub-subdivision b. of this subdivision: (i) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision, (ii) in the case of an individual becoming covered under a COBRA continuation provision, at the time the individual ceases to be covered under the COBRA continuation provision, and (iii) on the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in clause (i) or (ii) of this sub-subdivision, whichever is later.

The certification under clause (i) of this sub-subdivision may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

b. Certification. — The certification described in this sub-subdivision is a written certification of: (i) the period of creditable coverage of the individual under the plan and any coverage under the COBRA continuation provision, and (ii) any waiting period and affiliation period, if applicable, imposed with respect to the individual for any coverage under the plan.

(2) Disclosure of information on previous benefits. — In the case of an election described in sub-subdivision (c)(3)b. of this subsection by a group health insurer, if the health insurer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under subdivision (1) of this subsection:

a. Upon request of the health insurer, the entity that issued the certification provided by the individual shall promptly disclose to the requesting plan or health insurer information on coverage of classes and categories of health benefits available under the entity's coverage.

b. The entity may charge the requesting plan or health insurer for the reasonable cost of disclosing the information.

(f) Special Enrollment Periods. —

(1) Individuals losing other coverage. — A group health insurer shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of the employee if the dependent is eligible, but not enrolled, for coverage under the terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

a. The employee or dependent was covered under an ERISA group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.

b. The employee stated in writing at the time that coverage under the group health plan or health insurance coverage was the reason for declining enrollment, but only if the health insurer required the statement at the time and provided the employee with notice of the requirement and the consequences of the requirement at the time.

c. The employee's or dependent's coverage described in sub-subdivision a.: (i) was under a COBRA continuation provision and the coverage under the provision was exhausted; (ii) was not under that provision and either the coverage was terminated because of loss of eligibility for the coverage, including legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment; or (iii) employer contributions toward the coverage were terminated.

d. Under the terms of the plan, the employee requests the enrollment not later than 30 days after the date of exhaustion of coverage described in sub-subdivision c.(i) of this subdivision or termination of coverage or employer contribution described in sub-subdivision c.(ii) of this subdivision.

(2) For dependent beneficiaries. —

a. In general. — If: (i) a group health insurance plan makes coverage available with respect to a dependent of an individual, (ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period), and (iii) a person becomes the dependent of the individual through marriage, birth, or adoption or placement for adoption.

The plan shall provide for a dependent special enrollment period described in sub-subdivision b. of this subdivision during which the person (or, if not otherwise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if the spouse is othewise eligible for coverage.

b. Dependent special enrollment period. — A dependent special enrollment period under this sub-subdivision shall be a period of not less than 30 days and shall begin on the later of: (i) the date dependent coverage is made available, or (ii) the date of the marriage, birth, or adoption or placement for adoption described in sub-subdivision a.(iii) of this subdivision.

c. No waiting period. — If an individual seeks to enroll a dependent during the first 30 days of the dependent's special enrollment period, the coverage of the dependent shall become effective: (i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received; (ii) in the case of a dependent's birth, as of the date of the birth; or (iii) in the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(g) Use of Affiliation Period by HMO as Alternative to Preexisting Condition Exclusion. —

(1) In general. — A health maintenance organization that does not impose any preexisting condition exclusion allowed under subsection (a) of this section with respect to any particular coverage option may impose an affiliation period for the coverage option, but only if:

a. The period is applied uniformly without regard to any health status-related factors.
b. The period does not exceed two months (or three months in the case of a late enrollee).

(2) Affiliation period. —

a. Defined.— For the purposes of this Subpart, "affiliation period" means a period that, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. The health maintenance organization is not required to provide health care services or benefits during the period and no premium shall be charged to the participant or beneficiary for any coverage during the period.
b. Beginning. — The period shall begin on the enrollment date.
c. Runs concurrently with waiting periods. — An affiliation period under a plan shall run concurrently with any waiting period under the plan.

(3) Alternative methods. — A health maintenance organization described in subdivision (1) of this subsection may use alternative methods, as approved by the Commissioner, from those described in that subdivision, to address adverse selection. (1997-259, s. 1(c).)

Editor's Note. — Subsection (b) was set out in the form above at the direction of the Revisor of Statutes.

§ 58-68-35. Prohibiting discrimination against individual participants and beneficiaries based on health status.

(a) In Eligibility To Enroll. —

(1) In general. — Subject to subdivision (2) of this subsection, a group health insurer shall not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of the health insurer's plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

a. Health status.
b. Medical condition (including both physical and mental illnesses).
c. Claims experience.
d. Receipt of health care.
e. Medical history.
f. Genetic information.
g. Evidence of insurability (including conditions arising out of acts of domestic violence).
h. Disability.

(2) No application to benefits or exclusions. — To the extent consistent with G.S. 58-68-30, subdivision (1) of this subsection shall not be construed:

a. To require a group health insurance plan to provide particular benefits other than those provided under the terms of the plan, or

b. To prevent the plan from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan.

(3) Construction. — For the purposes of subdivision (1) of this subsection, rules for eligibility to enroll under a plan include rules defining any applicable waiting periods for the enrollment.

(b) In Premium Contributions. —

(1) In general. — A group health insurance plan shall not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of individual.

(2) Construction. — Nothing in subdivision (1) of this subsection shall be construed:

a. To restrict the amount that an employer may be charged for coverage under a group health insurance plan; or

b. To prevent a group health insurer from establishing premium discounts or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention. (1997-259, s. 1(c).)

2. Health Insurance Availability and Renewability.

§ 58-68-40. Guaranteed availability of coverage for employers in the small group market.

(a) Issuance of Coverage in the Small Group Market. —

(1) In general. — Subject to subsections (c) through (f) of this section, each health insurer that offers health insurance coverage in the small group market in this State:

a. Must accept every small employer that applies for the coverage; and

b. Must accept for enrollment under the coverage every eligible individual who applies for enrollment during the period in which the individual first becomes eligible to enroll under the terms of the group health insurance plan and shall not place any restriction that is inconsistent with G.S. 58-68-35 on an eligible individual being a participant or beneficiary.

(2) Eligible individual defined. — For the purposes of this section, "eligible individual" means, with respect to a health insurer that offers health insurance coverage to a small employer in the small group market, such an individual in relation to the employer as shall be determined:

a. In accordance with the terms of the plan,

b. As provided by the health insurer under rules of the health insurer that are uniformly applicable in this

State to small employers in the small group market, and

c. In accordance with all applicable State laws governing the health insurer and the market.

(b) Special Rules for Network Plans. —

(1) In general. — In the case of a health insurer that offers health insurance coverage in the small group market through a network plan, the health insurer may:

a. Limit the employers that may apply for coverage to those with eligible individuals who live, work, or reside in the service area for the network plan; and

b. Within the service area of the network plan, deny coverage to the employers if the health insurer has demonstrated to the Commissioner that: (i) it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees, and (ii) it is applying this subdivision uniformly to all employers without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to the employees and dependents.

(2) 180-day suspension upon denial of coverage. — A health insurer, upon denying health insurance coverage in any service area in accordance with sub-subdivision (1)b. of this subsection, shall not offer coverage in the small group market within the service area for a period of 180 days after the date the coverage is denied.

(c) Application of Financial Capacity Limits. —

(1) In general. — A health insurer may deny health insurance coverage in the small group market if the health insurer has demonstrated to the Commissioner that:

a. It does not have the financial reserves necessary to underwrite additional coverage; and

b. It is applying this subdivision uniformly to all employers in the small group market in the State consistent with this Chapter and without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to the employees and dependents.

(2) 180-day suspension upon denial of coverage. — A health insurer upon denying health insurance coverage in accordance with subdivision (1) of this subsection shall not offer coverage in the small group market in the State for a period of 180 days after the date the coverage is denied or until the health insurer has demonstrated to the Commissioner that the health insurer has sufficient financial reserves to underwrite additional coverage, whichever is later. The Commissioner may apply this subsection on a service-area-specific basis.

(d) Exception to Requirement for Failure to Meet Certain Minimum Participation or Contribution Rules. —

(1) In general. — Subsection (a) of this section does not preclude a health insurer from establishing employer contribution rules or group participation rules for the offering of health insurance coverage in connection with a group

health insurance plan in the small group market, as allowed under this Chapter.

(2) Rules defined. — For the purposes of subdivision (1) of this subsection:

a. "Employer contribution rule" means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries; and

b. "Group participation rule" means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer.

(e) Exception for Coverage Offered Only to Bona Fide Association Members. — Subsection (a) of this section does not apply to:

(1) Health insurance coverage offered by a health insurer if the coverage is made available in the small group market only through one or more bona fide associations.

(2) A self-employed individual as defined in G.S. 58-50-110(21a). (1997-259, s. 1(c).)

§ 58-68-45. Guaranteed renewability of coverage for employers in the group market.

(a) In General. — Except as provided in this section, if a health insurer offers health insurance coverage in the small or large group market, the health insurer must renew or continue in force the coverage at the option of the employer.

(b) General Exceptions. — A health insurer may nonrenew or discontinue health insurance coverage in the small or large group market based only on one or more of the following:

(1) Nonpayment of premiums. — The policyholder has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the health insurer has not received timely premium payments.

(2) Fraud. — The policyholder has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) Violation of participation or contribution rules. — The policyholder has failed to comply with a material plan provision relating to employer contribution or group participation rules, as permitted under G.S. 58-68-40(d) in the case of the small group market or pursuant to this Chapter in the case of the large group market.

(4) Termination of coverage. — The health insurer is ceasing to offer coverage in the market in accordance with subsection (c) of this section and this Chapter.

(5) Movement outside service area. — In the case of a health insurer that offers health insurance coverage in the market through a network plan, there is no longer any enrollee in connection with the network plan who lives, resides, or works in the service area of the health insurer or in the area for which the health insurer is authorized to do business and, in the case of the small group market, the health insurer would deny enrollment with respect to the network plan under G.S. 58-68-40(c)(1)a.

(6) Association membership ceases. — In the case of health insurance coverage that is made available in the small or large group market only through one or more bona fide associations, the membership of an employer in the association, on the basis of which the coverage is provided, ceases but only if the coverage is terminated under this subdivision uniformly without regard to any health status-related factor relating to any covered individual.

(c) Requirements for Uniform Termination of Coverage. —

(1) Particular type of coverage not offered. — In any case in which a health insurer decides to discontinue offering a particular type of group health insurance coverage offered in the small or large group market, coverage of the type may be discontinued by the health insurer in accordance with this Chapter in the market only if:

a. The health insurer provides notice to each policyholder provided coverage of this type in the market and to the participants and beneficiaries covered under the coverage of the discontinuation at least 90 days before the date of the discontinuation of the coverage;

b. The health insurer offers to each policyholder provided coverage of this type in the market the option to purchase all, or in the case of the large group market, any other health insurance coverage currently being offered by the health insurer to a group health insurance plan in the market; and

c. In exercising the option to discontinue coverage of this type and in offering the option of coverage under sub-subdivision b. of this subdivision, the health insurer acts uniformly without regard to the claims experience of those sponsors or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for the coverage.

(2) Discontinuance of all coverage. —

a. In general. — In any case in which a health insurer elects to discontinue offering all health insurance coverage in the small group market or the large group market, or both markets, in this State, health insurance coverage may be discontinued by the health insurer only in accordance with this Chapter and if: (i) the health insurer provides notice to the Commissioner and to each policyholder and to the participants and beneficiaries covered under the coverage of the discontinuation at least 180 days before the date of the discontinuation of the coverage; and (ii) all health insurance issued or delivered for issuance in this State in the market or markets are discontinued and coverage under the health insurance coverage in the market or markets is not renewed.

b. Prohibition on market reentry. — In the case of a discontinuation under sub-subdivision a. of this subdivision in a market, the health insurer shall not provide for the issuance of any health insurance coverage in that market in this State during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(d) Exception for Uniform Modification of Coverage. — At the time of coverage renewal, a health insurer may modify the health insurance coverage for a product offered to a group health insurance plan:

(1) In the large group market; or

(2) In the small group market if, for coverage that is available in the market other than only through one or more bona fide associations, the modification is consistent with this Chapter and effective on a uniform basis among group health insurance plans with that product.

(e) Application to Coverage Offered Only Through Associations. — In applying this section in the case of health insurance coverage that is made available by a health insurer in the small or large group market to employers only through one or more associations, a reference to "policyholder" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to the employer. (1997-259, s. 1(c); 1997-456, s. 42.)

Effect of Amendments. — The 1997 amendment, effective August 29, 1997, substituted "G.S. 58-68-40(d)" for "G.S. 58-68-40(c)" in subdivision (b)(3).

§ 58-68-50. Disclosure of information.

(a) Disclosure of Information by Health Insurers. — In connection with the offering of any health insurance coverage to a small employer, a health insurer:

(1) Shall make a reasonable disclosure to the employer, as part of its solicitation and sales materials, of the availability of information described in subsection (b) of this section, and

(2) Shall upon request of the small employer, provide the information.

(b) Information Described. —

(1) In general. — Subject to subdivision (3) of this subsection, with respect to a health insurer offering health insurance coverage to a small employer, information described in this subsection is information concerning:

a. The provisions of the coverage concerning the health insurer's right to change premium rates and the factors that may affect changes in premium rates;

b. The provisions of the coverage relating to renewability of coverage;

c. The provisions of the coverage relating to any preexisting condition exclusion; and

d. The benefits and premiums available under all health insurance coverage for which the employer is qualified.

(2) Form of information. — Information under this subsection shall be provided to small employers in a manner determined to be understandable by the average small employer, and shall be sufficient to reasonably inform small employers of their rights and obligations under the health insurance coverage.

(3) Exception. — A health insurer is not required under this section to disclose any information that is proprietary and trade secret information under applicable law. (1997-259, s. 1(c).)

3. Exclusion of Plans.

§ 58-68-55. Exclusion of certain plans.

(a) Exception for Certain Benefits. — The requirements of Subparts 1 and 2 of this Part do not apply to any group health insurance coverage in relation to its provision of excepted benefits described in G.S. 58-68-25(b)(1).

(b) Exception for Certain Benefits if Certain Conditions Met. —

(1) Limited, excepted benefits. — The requirements of Subparts 1 and 2 of this Part do not apply to any group health insurance plan in relation to its provision of excepted benefits described in G.S. 58-68-25(b)(2) if the benefits:

a. Are provided under a separate policy, certificate, or contract of insurance; or

b. Are otherwise not an integral part of the plan.

(2) Noncoordinated, excepted benefits. — The requirements of Subparts 1 and 2 of this Part do not apply to any group health insurance plan in relation to its provision of excepted benefits described in G.S. 58-68-25(b)(3) if all of the following conditions are met:

a. The benefits are provided under a separate policy, certificate, or contract of insurance.

b. There is no coordination between the provision of the benefits and any exclusion of benefits under any group health insurance plan maintained by the same policyholder.

c. The benefits are paid with respect to an event without regard to whether benefits are provided with respect to that event under any group health insurance plan maintained by the same policyholder.

(3) Supplemental, excepted benefits. — The requirements of this Part do not apply to any group health insurance plan in relation to its provision of excepted benefits described in G.S. 58-68-25(b)(4) if the benefits are provided under a separate policy, certificate, or contract of insurance. (1997-259, s. 1(c).)

Part B. Individual Market Reforms.

§ 58-68-60. Guaranteed availability of individual health insurance coverage to certain individuals with prior group coverage.

(a) Guaranteed Availability. —

(1) In general. — Subject to the succeeding subsections of this section, each health insurer that offers health insurance coverage in the individual market in this State shall not, with respect to an eligible individual desiring to enroll in individual health insurance coverage:

a. Decline to offer the coverage to, or deny enrollment of, the individual; or

b. Impose any preexisting condition exclusion with respect to the coverage.

(2) Reserved.

(b) Eligible Individual Defined. — In this Part, "eligible individual" means an individual:

(1)(i) For whom, as of the date on which the individual seeks coverage under this section, the aggregate of the periods of creditable coverage is 18 or more months and (ii) whose most recent prior creditable coverage was under an ERISA group health plan, governmental plan, or church plan (or health insurance coverage offered in connection with any such plan);

(2) Who is not eligible for coverage under (i) an ERISA group health plan, (ii) part A or part B of title XVIII of the Social Security Act, or (iii) a State plan under title XIX of the Act (or any successor program), and does not have other health insurance coverage;

(3) With respect to whom the most recent coverage within the coverage period described in subdivision (1)(i) was not terminated based on a factor described in G.S. 58-68-45(b)(1) or (b)(2);

(4) If the individual had been offered the option of continuation coverage under a COBRA continuation provision or under Article 53 of this Chapter, who elected the coverage; and

(5) Who, if the individual elected the continuation coverage, has exhausted the continuation coverage under the provision or program.

(c) Alternative Coverage Permitted. —

(1) In general. — In the case of health insurance coverage offered in this State, a health insurer may elect to limit the coverage offered under subsection (a) of this section as long as it offers at least two different policy forms of health insurance coverage both of which:

a. Are designed for, made generally available to, and actively marketed to, and enroll both eligible and other individuals by the health insurer; and

b. Meet the requirement of subdivision (2) or (3) of this subsection, as elected by the health insurer.

For the purposes of this subsection, policy forms that have different cost-sharing arrangements or different riders shall be considered to be different policy forms.

(2) Choice of most popular policy forms. — The requirement of this subdivision is met, for health insurance coverage policy forms offered by a health insurer in the individual market, if the health insurer offers the policy forms for individual health insurance coverage with the largest, and next to largest, premium volume of all the policy forms offered by the health insurer in this State or applicable marketing or service area (as may be prescribed by rules or regulations) by the health insurer in the individual market in the period involved.

(3) Choice of two policy forms with representative coverage. —

a. In general. — The requirement of this subdivision is met, for health insurance coverage policy forms offered by a health insurer in the individual market, if the health insurer offers a lower-level coverage policy form (as described in sub-subdivision b. of this subdivision) and a higher-level coverage policy form (as described in sub-subdivision c. of this subdivision) each of which includes benefits substantially similar to other individual health insurance coverage offered by the health insurer in this State.

b. Lower-level of coverage described. — A policy form is described in this sub-subdivision if the actuarial value of the benefits under the coverage is at least eighty-five percent (85%) but not greater than one hundred percent (100%) of a weighted average (described in sub-subdivision d. of this subdivision).

c. Higher-level of coverage described. — A policy form is described in this sub-subdivision if: (i) the actuarial value of the benefits under the coverage is at least fifteen percent (15%) greater than the actuarial value of the coverage described in sub-subdivision b. of this subdivision offered by the health insurer in the area involved; and (ii) the actuarial value of the benefits under the coverage is at least one hundred percent (100%) but not greater than one hundred twenty percent (120%) of a weighted average (described in sub-subdivision d. of this subdivision).

d. Weighted average. — For the purposes of this subdivision, the weighted average described in this sub-subdivision is the average actuarial value of the benefits provided by all the health insurance coverage issued, as elected by the health insurer, either by that health insurer or by all health insurers in this State in the individual market during the previous year, not including coverage issued under this section, weighted by enrollment for the different coverage.

(4) Election. — The health insurer elections under this subsection shall apply uniformly to all eligible individuals in this State for that health insurer. The election shall be effective for policies offered during a period of not less than two years.

(5) Assumptions. — For the purposes of subdivision (3) of this subsection, the actuarial value of benefits provided under individual health insurance coverage shall be calculated based on a standardized population and a set of standardized utilization and cost factors.

(d) Special Rules for Network Plans. —

(1) In general. — In the case of a health insurer that offers health insurance coverage in the individual market through a network plan, the health insurer may:

a. Limit the individuals who may be enrolled under the coverage to those who live, reside, or work within the service area for the network plan; and

b. Within the service area of the plan, deny the coverage to the individuals if the health insurer has demonstrated to the Commissioner that: (i) it will not have the capacity to deliver services adequately to additional individual enrollees because of its obligations to existing group contract holders and enrollees and individual enrollees, and (ii) it is applying this subdivision uniformly to individuals without regard to any health status-related factor of the individuals and without regard to whether the individuals are eligible individuals.

(2) 180-day suspension upon denial of coverage. — A health insurer, upon denying health insurance coverage in any service area in accordance with sub-subdivision (1)b. of this subdivision, shall not offer coverage in the individual market within the service area for a period of 180 days after the coverage is denied.

(e) Application of Financial Capacity Limits. —

(1) In general. — A health insurer may deny health insurance coverage in the individual market to an eligible individual if the health insurer has demonstrated to the Commissioner that:

a. It does not have the financial reserves necessary to underwrite additional coverage; and

b. It is applying this subdivision uniformly to all individuals in the individual market in this State consistent with this Chapter and without regard to any health status-related factor of the individuals and without regard to whether the individuals are eligible individuals.

(2) 180-day suspension upon denial of coverage. — A health insurer, upon denying individual health insurance coverage in any service area in accordance with subdivision (1) of this subsection, shall not offer the coverage in the individual market within the service area for a period of 180 days after the date the coverage is denied or until the health insurer has demonstrated to the Commissioner that the health insurer has sufficient financial reserves to underwrite additional coverage, whichever is later.

(f) Market Requirements. —

(1) In general. — Subsection (a) of this section does not require that a health insurer offering health insurance coverage only in connection with ERISA group health plans or through one or more bona fide associations, or both, offer the health insurance coverage in the individual market.

(2) Conversion policies. — A health insurer offering health insurance coverage in connection with group health plans under title XXVII of the federal Public Health Service Act shall not be deemed to be a health insurer offering individual health insurance coverage solely because the health insurer offers a conversion policy.

(g) Construction. — Nothing in this section shall be construed:

(1) To restrict the amount of the premium rates that a health insurer may charge an individual for health insurance coverage provided in the individual market under this Chapter; or

(2) To prevent a health insurer offering health insurance coverage in the individual market from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(h) Other Definitions. — As used in this section:

(1) "Church plan". — The meaning given the term under section 3(33) of the Employee Retirement Income Security Act of 1974.

(2) "Governmental plan". —

a. The meaning given the term under section 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan.

b. Federal governmental plan. — A governmental plan established or maintained for its employees by the government of the United States or by any agency or instrumentality of the government.

c. Nonfederal governmental plan. — A governmental plan that is not a federal governmental plan. (1997-259, s. 1(c).)

Editor's Note. — Session Laws 1997-259, s. 26, made this Part effective July 1, 1997.

Subsection (a) was set out in the form above at the direction of the Revisor of Statutes.

§ 58-68-65. Guaranteed renewability of individual health insurance coverage.

(a) In General. — Except as provided in this section, a health insurer that provides individual health insurance coverage to an individual shall renew or continue in force the coverage at the option of the individual.

(b) General Exceptions. — A health insurer may nonrenew or discontinue health insurance coverage of an individual in the individual market based only on one or more of the following:

(1) Nonpayment of premiums. — The individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the health insurer has not received timely premium payments.

(2) Fraud. — The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) Termination of plan. — The health insurer is ceasing to offer coverage in the individual market in accordance with subsection (c) of this section and this Chapter.

(4) Movement outside service area. — In the case of a health insurer that offers health insurance coverage in the market through a network plan, the individual no longer resides, lives, or works in the service area (or in an area for which the health insurer is authorized to do business) but only if the coverage is terminated under this subdivision uniformly without regard to any health status-related factor of covered individuals.

(5) Association membership ceases. — In the case of health insurance coverage that is made available in the individual market only through one or more bona fide associations, the membership of the individual in the association (on the basis of which the coverage is provided) ceases but only if the coverage is terminated under this subdivision uniformly without regard to any health status-related factor of covered individuals.

(c) Requirements for Uniform Termination of Coverage. —

(1) Particular type of coverage not offered. — In any case in which a health insurer decides to discontinue offering a particular type of health insurance coverage offered in the individual market, coverage of the type may be discontinued by the health insurer only if:

a. The health insurer provides notice, notwithstanding G.S. 58-51-20 or G.S. 58-65-60(c)(3)b., to each covered individual provided coverage of this type in the market of the discontinuation at least 90 days before the date of the discontinuation of the coverage;

b. The health insurer offers to each individual in the individual market provided coverage of this type, the option to purchase any other individual health insurance coverage currently being offered by the health insurer for individuals in the market; and

c. In exercising the option to discontinue coverage of this type and in offering the option of coverage under sub-subdivision b. of this subdivision, the health insurer acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for the coverage.

(2) Discontinuance of all coverage. —

a. In general. — Subject to sub-subdivision c. of this subdivision, in any case in which a health insurer elects to discontinue offering all health insurance coverage in the individual market in this State, health insurance coverage may be discontinued by the health insurer only if: (i) the health insurer provides notice to the Commissioner and to each individual of the discontinuation at least 180 days before the date of the expiration of the coverage, and (ii) all health insurance coverage issued or delivered for issuance in this State in the market is discontinued and the health insurance coverage in the market is not renewed.

b. Prohibition on market reentry. — In the case of a discontinuation under sub-subdivision a. of this subdivision in the individual market, the health insurer shall not provide for the issuance of any health insurance coverage in the market and this State during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(d) Exception for Uniform Modification of Coverage. — At the time of coverage renewal, a health insurer may modify the health insurance coverage for a policy form offered to individuals in the individual market as long as the modification is consistent with State law and effective on a uniform basis among all individuals with that policy form.

(e) Application to Coverage Offered Only Through Associations. — In applying this section in the case of health insurance coverage that is made available by a health insurer in the individual market to individuals only through one or more associations, a reference to an "individual" is deemed to include a reference to the association of which the individual is a member. (1997-259, s. 1(c).)

§ 58-68-70. Certification of coverage.

G.S. 58-68-30(e) applies to health insurance coverage offered by a health insurer in the individual market in the same manner that it applies to health insurance coverage offered by a health insurer in the small or large group market. (1997-259, s. 1(c).)

§ 58-68-75. General exceptions.

(a) Exception for Certain Benefits. — This Part does not apply to any health insurance coverage in relation to its provision of excepted benefits described in G.S. 58-68-25(b)(1).

(b) Exception for Certain Benefits if Certain Conditions Met. — This Part does not apply to any health insurance coverage in relation to its provision of excepted benefits described in G.S. 58-68-25(b)(2), (3), or (4) if the benefits are provided under a separate policy, certificate, or contract of insurance. (1997-259, s. 1(c).)

ARTICLE 68A.

Health Care Reform Planning.

§§ 58-68A-1 through 58-68A-10: Repealed by Session Laws 1995 (Regular Session, 1996), c. 17, s. 16, effective January 1, 1997.

Editor's Note. — Session Laws 1996, Second Extra Session, c. 17, s. 1, provides that this act shall be known as "The Studies Act of 1996."

ARTICLE 71.

Bail Bondsmen and Runners.

§ 58-71-1. Definitions.

The following words when used in this Article shall have the following meanings:

(1) "Accommodation bondsman" is a natural person who has reached the age of 18 years and is a bona fide resident of this State and who, aside from love and affection and release of the person concerned, receives no consideration for action as surety and who endorses the bail bond after providing satisfactory evidences of ownership, value and marketability of real or personal property to the extent necessary to reasonably satisfy the official taking bond that such real or personal property will in all respects be sufficient to assure that the full principal sum of the bond will be realized in the event of breach of the conditions thereof. "Consideration" as used in this subdivision does not include the legal rights of a surety against a principal by reason of breach of the conditions of a bail bond nor does it include collateral furnished to and securing the surety so long as the value of the surety's rights in the collateral do not exceed the principal's liability to the surety by reason of a breach in the conditions of said bail bond.

(2) "Bail bond" shall mean an undertaking by the principal to appear in court as required upon penalty of forfeiting bail to the State in a stated amount; and may include an unsecured appearance bond, a premium-secured appearance bond, an appearance bond secured by a cash deposit of the full amount of the bond, an appearance bond secured by a

mortgage pursuant to G.S. 58-74-5, and an appearance bond secured by at least one surety.

(3) "Bail bondsman" shall mean a surety bondsman, professional bondsman or an accommodation bondsman as hereinafter defined.

(4) "Commissioner" shall mean the Commissioner of Insurance.

(5) "Insurer" shall mean any domestic, foreign, or alien surety company which has qualified generally to transact surety business and specifically to transact bail bond business in this State.

(6) "Obligor" shall mean a principal or a surety on a bail bond.

(7) "Principal" shall mean a defendant or witness obligated to appear in court as required upon penalty of forfeiting bail under a bail bond.

(8) "Professional bondsman" shall mean any person who is approved and licensed by the Commissioner and who pledges cash or approved securities with the Commissioner as security for bail bonds written in connection with a judicial proceeding and receives or is promised money or other things of value therefor.

(9) "Runner" shall mean a person employed by a bail bondsman for the purpose of assisting the bail bondsman in presenting the defendant in court when required, or to assist in apprehension and surrender of defendant to the court, or keeping defendant under necessary surveillance, or to execute bonds on behalf of the licensed bondsman when the power of attorney has been duly recorded. "Runner" does not include, however, a duly licensed attorney-at-law or a law-enforcement officer assisting a bondsman.

(10) "Surety" shall mean one who, with the principal, is liable for the amount of the bail bond upon forfeiture of bail.

(11) "Surety bondsman" means any person who is licensed by the Commissioner as a surety bondsman under this Article, is appointed by an insurer by power of attorney to execute or countersign bail bonds for the insurer in connection with judicial proceedings, and receives or is promised consideration for doing so. (1963, c. 1225, s. 1; 1975, c. 619, s. 1; 1995 (Reg. Sess., 1996), c. 726, s. 1.)

Editor's Note. —

Session Laws 1995 (Reg. Sess., 1996), c. 726, s. 21, provides that all surety bondsmen holding licenses issued under G.S. 58-33-25(e)(9) shall be issued surety bondsmen licenses under Article 71 of Chapter 58 of the General Statutes.

Session Laws 1995 (Reg. Sess., 1996), c. 726, s. 22, is a severability clause.

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective January 1, 1997, in subdivision (11), substituted "means any person who is licensed by the Commissioner as a surety bondsman under this Article, is" for "shall mean any person who is approved by and licensed by the Commissioner as an insurance agent pursuant to the provisions of Articles 1 through 64 of this Chapter and", substituted "consideration for doing so" for "money or other things of value therefor", and made a punctuation change.

§ 58-71-40. Bail bondsmen and runners to be qualified and licensed; license applications generally.

(a) No person shall act in the capacity of a bail bondsman or runner or perform any of the functions, duties, or powers prescribed for bail bondsmen or runners under the provisions of this Article unless that person shall be qualified and (except as regards an accommodation bondsman) licensed in accordance with the provisions of this Article. No license shall be issued to a professional bondsman or runner except to an individual natural person.

(b) The applicant shall apply for a license on forms prepared and supplied by the Commissioner and the Commissioner may propound any reasonable interrogatories to an applicant for a license under this Article relating to the applicant's qualifications, residence, prospective place of business, and any other matters which, in the opinion of the Commissioner, are deemed necessary in order to protect the public and ascertain the qualifications of the applicant. The Commissioner may also conduct any reasonable inquiry or investigation relative to the determination of the applicant's fitness to be licensed or to continue to be licensed.

(c) A person whose application is denied may reapply, but the Commissioner may not consider more than one application submitted by the same person within any one-year period.

(d) When a license is issued under this section, the Commissioner shall issue a picture identification card, of design, size, and content approved by the Commissioner, to the licensee. Each licensee must carry this card at all times when working in the scope of the licensee's employment. A licensee whose license is terminated must surrender the identification card to the Commissioner within 10 working days of the termination. (1963, c. 1225, s. 9; 1975, c. 619, s. 1; 1995 (Reg. Sess., 1996), c. 726, s. 2.)

Editor's Note. — Session Laws 1995 (Reg. Sess., 1996), c. 726, s. 22, is a severability clause.

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective January 1, 1997, deleted "only individuals to be licensed" following "qualified and licensed" in the catchline; added the subsection (a), (b), and (c) designations; deleted "as provided in this Article and none shall be issued except" following "bondsman or runner except" in the second sentence of subsection (a); in subsection (b), in the first sentence, substituted "a license" for "license or renewal thereof" following "shall apply for", and substituted "relating to the applicant's" for "or any renewal thereof, relating to his" following "under this Article", and, in the second sentence, deleted "he sees fit" following "reasonable inquiry or investigation"; rewrote subsection (c); and added subsection (d).

§ 58-71-45. Terms of licenses.

A license issued to a bail bondsman or to a runner authorizes the licensee to act in that capacity until the license is suspended or revoked. Upon the suspension or revocation of a license, the licensee shall return the license to the Commissioner. A license of a bail bondsman and a license of a runner shall be renewed on July 1 of each year upon payment of the applicable renewal fee under G.S. 58-71-75. The Commissioner is not required to print renewal licenses. After notifying the Commissioner in writing, a professional bondsman who employs a runner may cancel the runner's license and the runner's authority to act for the professional bondsman. (1963, c. 1225, s. 10; 1975, c. 619, s. 1; 1995 (Reg. Sess., 1996), c. 726, s. 3.)

Editor's Note. — Session Laws 1995 (Reg. Sess., 1996), c. 726, s. 22, is a severability clause.

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective January 1, 1997, substituted "Terms" for "Expiration" in the catchline; and rewrote this section.

§ 58-71-50. Qualification for bail bondsmen and runners.

(a) An applicant for a license as a bail bondsman or runner, must furnish the Commissioner a complete set of the applicant's fingerprints and a recent passport size full-face photograph of the applicant. The applicant's fingerprints shall be certified by an authorized law-enforcement officer. The fingerprints of every applicant shall be forwarded to the State Bureau of Investigation for a search of the applicant's criminal history record file, if any. If warranted, the State Bureau of Investigation shall forward a set of the fingerprints to the Federal Bureau of Investigation for a national criminal history record check. An applicant shall pay the cost of the State and any national criminal history record check of the applicant.

(b) Every applicant for a license under this Article as a bail bondsman or runner must meet all of the following qualifications:

(1) Be 18 years of age or over.

(2) Be a resident of this State.

(3) Be a person of good moral character and not have been convicted of a felony or any crime involving moral turpitude.

(4) Have knowledge, training, or experience of sufficient duration and extent to provide the competence necessary to fulfill the responsibilities of a licensee.

(5) Have no outstanding bail bond obligations.

(6) Have no current or prior violations of any provision of this Article or of Article 26 of Chapter 15A of the General Statutes or of any similar provision of law of any other state.

(7) Not have been in any manner disqualified under the laws of this State or any other state to engage in the bail bond business. (1963, c. 1225, s. 11; 1971, c. 1231, s. 1; 1975, c. 619, s. 1; 1987, c. 728, s. 1; 1989, c. 485, s. 39; 1991, c. 720, s. 41; 1995 (Reg. Sess., 1996), c. 726, s. 4.)

Editor's Note. — Session Laws 1995 (Reg. Sess., 1996), c. 726, s. 22, is a severability clause.

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective January 1, 1997, substituted "bail" for "professional" in the catchline; and rewrote this section.

§ 58-71-55. License fees.

A nonrefundable license fee of one hundred dollars ($100.00) shall be paid to the Commissioner with each application for license as a bail bondsman and a license fee of sixty dollars ($60.00) shall be paid to the Commissioner with each application for license as a runner. (1963, c. 1225, s. 12; 1975, c. 619, s. 1; 1983, c. 790, s. 11; 1991, c. 721, s. 4; 1995 (Reg. Sess., 1996), c. 726, s. 5.)

Editor's Note. — Session Laws 1995 (Reg. Sess., 1996), c. 726, s. 22, is a severability clause.

Effect of Amendments. — The 1995

(Reg. Sess., 1996) amendment, effective January 1, 1997, substituted "bail" for "professional" preceding "bondsman".

§ 58-71-60: Repealed by Session Laws 1995 (Regular Session, 1996), c. 726, s. 6, effective October 1, 1996.

Editor's Note. — Session Laws 1995 (Reg. Sess., 1996), c. 726, s. 22, is a severability clause.

§ 58-71-65. Contents of application for runner's license; endorsement by professional bondsman.

In addition to the other requirements of this Article, an applicant for a license to be a runner must affirmatively show:

(1) That the applicant will be employed by only one professional bondsman, who will supervise the work of the applicant and be responsible for the runner's conduct in the bail bond business.

(2) That the application is endorsed by the appointing professional bondsman, who must agree in the application to supervise the runner's activities.

(3) Whether or not the applicant has ever been licensed as a bail bondsman or runner. An applicant who has been licensed as a bail bondsman must list all outstanding bail bond obligations. An applicant who has been licensed as a runner must list all prior employment as such, indicating the name of each supervising professional bondsman and the reasons for the termination of the employment. (1963, c. 1225, s. 14; 1975, c. 619, s. 1; 1987, c. 728, s. 2; 1995 (Reg. Sess., 1996), c. 726, s. 7.)

Editor's Note. — Session Laws 1995 (Reg. Sess., 1996), c. 726, s. 22, is a severability clause.

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective January 1, 1997, rewrote this section.

§ 58-71-70. Examination; fees.

Each applicant for a license as a professional bondsman, surety bondsman, or runner shall appear in person and take a written examination prepared by the Commissioner testing the applicant's ability and qualifications. Each applicant is eligible for examination 30 days after the date the application is received by the Commissioner. Each examination shall be held at a time and place as designated by the Commissioner. Each applicant shall be given notice of the designated time and place no sooner than 15 days before the examination. The Commissioner may contract with a person to process applications for the examination and administer and grade the examination in the same manner as for agent examinations under Article 33 of this Chapter.

The fee for each examination is twenty-five dollars ($25.00) plus an amount that offsets the cost of any contract for examination services. This examination fee is nonrefundable.

An applicant who fails an examination may take a subsequent examination, but at least one year must intervene between examinations. (1963, c. 1225, s. 15; 1975, c. 619, s. 1; 1991, c. 721, s. 5; 1995 (Reg. Sess., 1996), c. 726, s. 8.)

Editor's Note. — Session Laws 1995 (Reg. Sess., 1996), c. 726, s. 22, is a severability clause.

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective January 1, 1997, rewrote this section.

§ 58-71-71. Examination; educational requirements; penalties.

(a) In order to be eligible to take the examination required to be licensed as a runner or bail bondsman under G.S. 58-71-70, each person shall complete at least 20 hours of education in subjects pertinent to the duties and responsibilities of a runner or bail bondsman, including all laws and regulations related to being a runner or bail bondsman.

(b) Each year every licensee shall complete at least 10 hours of continuing education in subjects related to the duties and responsibilities of a runner or bail bondsman before renewal of the license. This continuing education shall not include a written or oral examination. A person who receives his first license on or after January 1 of any year does not have to comply with this subsection until the period between his first and second license renewals.

(c) Any person licensed as a runner or bail bondsman before January 1, 1994, is not subject to the prelicensing education requirement of this section, but is subject to the continuing education requirement of this section. A licensed runner or bail bondsman who is 65 years of age or older and who has been licensed as a runner or bail bondsman for 15 years or more is exempt from both the prelicensing education and continuing education requirements of this section.

(d) Educational courses offered under this section must be approved by the Commissioner before they may be offered. Before approving a course, the Commissioner must be satisfied that it will enhance the professional competence and professional responsibility of bail bondsmen and runners. No person shall offer, sponsor, or conduct any course under this section unless the Commissioner has authorized that person to do so.

(e) Any person who falsely represents to the Commissioner that the requirements of this section have been met is subject, after notice and opportunity for hearing, to G.S. 58-2-70.

(f) The Commissioner may adopt rules for the effective administration of this section. (1993, c. 409, s. 22; 1993 (Reg. Sess., 1994), c. 678, s. 32; 1995 (Reg. Sess., 1996), c. 726, s. 9.)

Editor's Note. — Session Laws 1995 (Reg. Sess., 1996), c. 726, s. 22, is a severability clause.

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective January 1, 1997, in subsection (d), deleted "The Commissioner shall approve the" from the beginning, substituted "must be approved by the Commissioner before they may be offered" for "and ensure that they", inserted "Before approving a course, the Commissioner must be satisfied that it will", and deleted "the auspices of" following "any course under" in the last sentence.

§ 58-71-72. Qualifications of instructors.

(a) A person who provides, presents, or instructs a prelicensing course or continuing education course under G.S. 58-71-71 must have a certificate of authority issued by the Commissioner. The Commissioner may establish requirements for the issuance or renewal of a certificate of authority and grounds for the summary suspension or termination of a certificate of authority.

(b) The Commissioner may summarily suspend or terminate a certificate of authority to provide, present, or instruct a course if the Commissioner finds that the course is inaccurate or it received a poor evaluation from both a Department monitor and a majority of those who attended the course and responded to a Department questionnaire about the course. (1995 (Reg. Sess., 1996), c. 726, s. 10.)

Editor's Note. — Session Laws 1995 (Reg. Sess., 1996), c. 726, s. 22, is a severability clause.

Session Laws 1995 (Reg. Sess., 1996), c. 726, s. 23, made this section effective January 1, 1997.

§ 58-71-75. Renewal fees.

The renewal fee for a runner's license is sixty dollars ($60.00). The renewal fee for a bail bondsman's license is one hundred dollars ($100.00). A renewed license continues in effect until suspended or revoked for cause. (1963, c. 1225, s. 16; 1975, c. 619, s. 1; 1991, c. 721, s. 6; 1995 (Reg. Sess., 1996), c. 726, s. 11.)

Editor's Note. —
Session Laws 1995 (Reg. Sess., 1996), c. 726, s. 22, is a severability clause.

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective January 1, 1997, rewrote this section.

§ 58-71-81. Notice of receivership.

Upon the filing for protection under the United States Bankruptcy Code or any state receivership law by any bail bondsman licensed under this Article or by any bail bond business in which the bondsman holds a position of management or ownership, the bondsman shall notify the Commissioner of the filing for protection within three business days after the filing. Upon the appointment of a receiver by a State or federal court for any professional bondsman licensed under this Article, or for any bail bond business in which the bondsman holds a position of management or ownership, the bondsman shall notify the Commissioner of the filing for protection within three business days after the filing. The failure to notify the Commissioner within three business days after the filing for bankruptcy protection shall, after hearing, cause the license of any person failing to make the required notification to be suspended for a period of not less than 60 days nor more than three years, in the discretion of the Commissioner. (1993, c. 409, s. 17; 1995 (Reg. Sess., 1996), c. 726, s. 12.)

Editor's Note. —
Session Laws 1995 (Reg. Sess., 1996), c. 726, s. 22, is a severability clause.

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective January 1, 1997, substituted "or any state receivership law by any bail" for "by any professional" preceding "bondsman licensed under this Article" in the first sentence.

§ 58-71-82. Dual license holding.

If an individual holds a professional bondsman's license or a runner's license and a surety bondsman's license simultaneously, they are considered one license for the purpose of suspension, revocation, or renewal under this Article. Separate renewal fees must be paid for each license, however. (1995 (Reg. Sess., 1996), c. 726, ss. 13, 15.)

Editor's Note. — Session Laws 1995 (Reg. Sess., 1996), c. 726, s. 13, which enacted this section effective June 21, 1996, read as follows: "If licenses are issued to a bail bondsman or runner under this Article and under Article 33 of this Chapter and the license issued under Article 33 of this Chapter is suspended or revoked for cause or is not renewed, the license issued under this Article is suspended, revoked, or not renewed as of the date the order under Article 33 of this Chapter is final."

Session Laws 1995 (Reg. Sess., 1996), c. 726, s. 13, made this section effective upon ratification. The Act was ratified June 21, 1996.

Session Laws 1995 (Reg. Sess., 1996), c. 726, s. 22, is a severability clause.

Effect of Amendments. — Session Laws 1995 (Reg. Sess., 1996), c. 726, s. 15, effective January 1, 1997, rewrote this section. For version of this section as enacted effective June 21, 1996, see editor's note.

§ 58-71-95. Prohibited practices.

No bail bondsman or runner shall:

(1) Pay a fee or rebate or give or promise anything of value, directly or indirectly, to a jailer, law-enforcement officer, committing magistrate, or any other person who has power to arrest or hold in custody, or to any public official or public employee in order to secure a settlement, compromise, remission or reduction of the amount of any bail bond or the forfeiture thereof, including the payment to law-enforcement officers, directly or indirectly, for the arrest or apprehension of a principal or principals who have caused or will cause a forfeiture.

(2) Pay a fee or rebate or give anything of value to an attorney in bail bond matters, except in defense of any action on a bond.

(3) Pay a fee or rebate or give or promise anything of value to the principal or anyone in his behalf.

(4) Participate in the capacity of an attorney at a trial or hearing of one on whose bond he is surety, nor suggest or advise the employment of, or name for employment any particular attorney to represent his principal.

(5) Accept anything of value from a principal or from anyone on behalf of a principal except the premium, which shall not exceed fifteen percent (15%) of the face amount of the bond; provided that the bondsman shall be permitted to accept collateral security or other indemnity from a principal or from anyone on behalf of a principal. Such collateral security or other indemnity required by the bondsman must be reasonable in relation to the amount of the bond and shall be returned upon final termination of liability on the bond.

(6) Solicit business in any of the courts or on the premises of any of the courts of this State, in the office of any magistrate and in or about any place where prisoners are

confined. Loitering in or about a magistrate's office or any place where prisoners are confined shall be prima facie evidence of soliciting.

(7) Advise or assist the principal for the purpose of forfeiting bond.

(8) Impersonate a law-enforcement officer.

(9) Falsely represent that the bail bondsman or runner is in any way connected with an agency of the federal government or of a state or local government. (1963, c. 1225, s. 20; 1975, c. 619, s. 1; 1993, c. 409, s. 18; 1995 (Reg. Sess., 1996), c. 726, s. 16.)

Editor's Note. — Session Laws 1995 (Reg. Sess., 1996), c. 726, s. 22, is a severability clause.

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective October 1, 1996, added subdivisions (8) and (9).

§ 58-71-105. Persons prohibited from becoming surety or runners.

No sheriff, deputy sheriff, other law-enforcement officer, judicial official, attorney, parole officer, probation officer, jailer, assistant jailer, employee of the General Court of Justice, nor other public employee assigned to duties relating to the administration of criminal justice, nor the spouse of any such person, may in any case become surety on a bail bond for any person. In addition, no person covered by this section may act as an agent for any bonding company or bail bondsman. No such person may have an interest, directly or indirectly, in the financial affairs of any firm or corporation whose principal business is acting as a bail bondsman. However, nothing in this section prohibits any such person from being surety upon the bond of his or her spouse, parent, brother, sister, child, or descendant. (1963, c. 1225, s. 22; 1973, c. 108, s. 39; 1975, c. 619, s. 1; 1991, c. 644, s. 18; 1995 (Reg. Sess., 1996), c. 726, s. 17.)

Editor's Note. — Session Laws 1995 (Reg. Sess., 1996), c. 726, s. 22, is a severability clause.

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective January 1, 1997, substituted "bail" for "professional" preceding "bondsman" in the second sentence.

§ 58-71-115. Insurers to annually report surety bondsmen; notices of appointments and terminations; information confidential.

Before July 1 of each year, every insurer shall furnish the Commissioner a list of all surety bondsmen appointed by the insurer to write bail bonds on the insurer's behalf. An insurer who appoints a surety bondsman in the State on or after July 1 of each year must notify the Commissioner of the appointment. All appointments are subject to the issuance of the proper license to the appointee under this Article.

An insurer terminating the appointment of a surety bondsman shall file a written notice of the termination with the Commissioner, together with a statement that the insurer has given or mailed notice to the surety bondsman and to the clerk of superior court of any county in the State in which the insurer has been obligated on bail bonds through the surety bondsman within the past three years. The notice to the Commissioner shall state the reasons, if any, for the termination. Information furnished in the notice to the Commissioner shall be privileged and shall not be used as evidence in or basis for any action against the insurer or any of its representatives. (1963, c. 1225, s. 24; 1975, c. 619, s. 1; 1995 (Reg. Sess., 1996), c. 726, s. 18.)

Editor's Note. — Session Laws 1995 (Reg. Sess., 1996), c. 726, s. 22, is a severability clause.

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective January 1, 1997, rewrote this section.

§ 58-71-140. Registration of licenses and power of appointments by insurers.

(a) No professional bail bondsman shall become a surety on an undertaking unless he or she has registered his or her current license in the office of the clerk of superior court in the county in which he or she resides and a certified copy of the same with the clerk of superior court in any other county in which he or she shall write bail bonds.

(b) A surety bondsman shall register his or her current surety bondsman's license and a certified copy of his or her power of appointment with the clerk of superior court in the county in which the surety bondsman resides and with the clerk of superior court in any other county in which the surety bondsman writes bail bonds on behalf of an insurer.

(c) No runner shall become surety on an undertaking on behalf of a professional bondsman unless that runner has registered his or her current license and a certified copy of his or her power of attorney in the office of the clerk of superior court in the county in which the runner resides and with the clerk of superior court in any other county in which the runner writes bail bonds on behalf of the professional bondsman. (1963, c. 1225, s. 31; 1975, c. 619, s. 1; 1995 (Reg. Sess., 1996), c. 726, s. 19.)

Editor's Note. — Session Laws 1995 (Reg. Sess., 1996), c. 726, s. 22, is a severability clause.

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective January 1, 1997, added the subsection (a) and (b) designations; in subsection (a), inserted "or she" following "he" in three places, and inserted "or her" following "his"; rewrote subsection (b); and added subsection (c).

ARTICLE 75.

Deposit in Lieu of Bond.

§ 58-75-1. Deposit of cash or securities in lieu of bond; conditions and requirements.

CASE NOTES

Waiver of Exemptions. — When husband elected to deposit cash bond in lieu of surety bond to stay the execution of a judgment against him for spousal support and breach of separation agreement, husband waived any exemption to which he otherwise may have been entitled. Barrett v. Barrett, 122 N.C. App. 264, 468 S.E.2d 264 (1996).

Since the primary purpose of a bond is to provide a source of funds to be applied to the satisfaction of a valid judgment, as a matter of public policy, a party is not permitted to post a cash bond to stay execution of a money judgment and then avoid forfeiture of the bond after default by claiming debtor's exemptions. Barrett v. Barrett, 122 N.C. App. 264, 468 S.E.2d 264 (1996).

ARTICLE 76.

Actions on Bonds.

§ 58-76-5. Liability and right of action on official bonds.

Every person injured by the neglect, misconduct, or misbehavior in office of any clerk of the superior court, register, surveyor, sheriff, coroner, county treasurer, or other officer, may institute a suit or suits against said officer or any of them and their sureties upon their respective bonds for the due performance of their duties in office in the name of the State, without any assignment thereof; and no such bond shall become void upon the first recovery, or if judgment is given for the defendant, but may be put in suit and prosecuted from time to time until the whole penalty is recovered; and every such officer and the sureties on his official bond shall be liable to the person injured for all acts done by said officer by virtue or under color of his office. (1793, c. 384, s. 1, P.R.; 1825, c. 9, P.R.; 1833, c. 17; R.C., c. 78, s. 1; 1869-70, c. 169, s. 10; Code, s. 1883; Rev., s. 281; C.S., s. 354; 1973, c. 108, s. 59; 1997-14, s. 2.)

Effect of Amendments. — The 1997 amendment, effective April 3, 1997, deleted "entry-taker" preceding "surveyor" near the beginning of the section.

CASE NOTES

Suits Against a Sheriff. — The legislature has prescribed two ways for a sheriff to be sued in his official capacity, this section and § 153A-435. Smith v. Phillips, 117 N.C. App. 378, 451 S.E.2d 309 (1994).

Immunity from Prosecution Not Surrendered. — As sheriffs are state officials, without specific reference to the Eleventh Amendment of the United States Constitution in the text of this section, no immunity from prosecution of sheriffs or their deputies is surrendered by this section. Braswell v. Ellis, 950 F. Supp. 145 (E.D.N.C. 1995).

ARTICLE 78.

State Fire and Rescue Commission.

§ 58-78-1. State Fire and Rescue Commission created; membership.

(a) There is created the State Fire and Rescue Commission of the Department, which shall be composed of 15 voting members to be appointed as follows:

(1) The Commissioner shall appoint 12 members, two from nominations submitted by the North Carolina State Firemen's Association, one from nominations submitted by the North Carolina Association of Fire Chiefs, one from nominations submitted by the Professional Firefighters of North Carolina Association, one from nominations submitted by the North Carolina Society of Fire Service Instructors, one from nominations submitted by the North Carolina Association of County Fire Marshals, one from nominations submitted by the North Carolina Fire Marshal's Association, two from nominations submitted by the North Carolina Association of Rescue and Emergency Medical Services, Inc., one mayor or other elected city official nominated by the President of the League of Municipalities, one county commissioner nominated by the President of the Association of County Commissioners, and one from the public at large;

(2) The Governor shall appoint one member from the public at large; and

(3) The General Assembly shall appoint two members from the public at large, one upon the recommendation of the Speaker of the House of Representatives pursuant to G.S. 120-121, and one upon the recommendation of the President Pro Tempore of the Senate pursuant to G.S. 120-121.

Public members may not be employed in State government and may not be directly involved in fire fighting or rescue services.

(b) Of the members initially appointed by the Commissioner, the nominees of the North Carolina State Firemen's Association and the nominees of the North Carolina Association of Fire Chiefs and the nominees of the Professional Firefighters of North Carolina Association and of the North Carolina Association of Rescue and Emergency Medical Services, Inc., shall serve three-year terms; the nominees from the North Carolina Society of Fire Service Instructors, the North Carolina Association of County Fire Marshals, and the North Carolina Fire Marshal's Association shall serve two-year terms; and the mayor or other elected city official, the county commissioner, and the member from the public at large shall serve one-year terms. The Governor's initial appointee shall serve a three-year term. The General Assembly's initial appointees shall serve two-year terms. Thereafter all terms shall be for three years.

(c) Vacancies shall be filled by the original appointer in the same manner as the original appointment was made, except that vacancies in the appointments made by the General Assembly shall be filled in accordance with G.S. 120-122.

(d) Appointed members shall serve until their successors are appointed and qualified.

(e) The following State officials, or their designees, shall serve by virtue of their offices as nonvoting members of the Commission: the Commissioner of Insurance, the Commissioner of Labor, the Attorney General, the Secretary of Crime Control and Public Safety, the Secretary of Environment and Natural Resources, and the President of the Department of Community Colleges.

(f) Members of the Commission shall receive per diem and necessary travel and subsistence allowances in accordance with the provisions of G.S. 138-5 or G.S. 138-6, as appropriate. (1977, c. 1064, s. 1; 1981, c. 791, ss. 1, 2; 1981 (Reg. Sess., 1982), c. 1191, ss. 21, 22;

1983, c. 840, ss. 1, 2; 1985, c. 757, s. 167(b), (d); 1989, c. 727, s. 218; c. 750, s. 1; 1991, c. 720, s. 47; 1993, c. 155, s. 1; 1995, c. 490, s. 20; 1997-116, s. 1; 1997-443, s. 11A.123.)

Editor's Note. — Session Laws 1995, c. 490, which amended this section, in s. 65 provides: "This act applies with respect to terms beginning on or after January 1, 1997, and to vacancies occurring on or after that date regardless of the date the term began."

Session Laws 1997-443, s. 1.1, provides: "This act shall be known as 'The Current Operations and Capital Improvements Appropriations Act of 1997.'"

Session Laws 1997-443, s. 3.4, is severability clause.

Effect of Amendments. — Session Laws 1997-116, s. 1, effective May 29, 1997, substituted "15 voting members" for "14 voting members" in the introductory language of subsection (a); substituted "12 members" for "eleven members" and inserted "one from nominations submitted by the Professional Firefighters of North Carolina Association" in subdivision (a)(1); and inserted "and the nominees of the Professional Firefighters of North Carolina Association" in the first sentence of subsection (b).

The 1997 amendment, effective August 28, 1997, substituted "Environment and Natural Resources" for "Environment, Health, and Natural Resources."

§ 58-78-5. State Fire and Rescue Commission — Powers and duties.

(a) The Commission shall have the following powers and duties:

(1) To formally adopt a State Fire Education and Training Plan, a State Master Plan for Fire Prevention and Control, a Rescue Training Plan, and a State Master Plan for Rescue Services;

(2) To assist and participate with State and local fire prevention and control agencies in the improvement of fire prevention and control in North Carolina and to work with State and local rescue agencies to improve rescue services in the State;

(3) To increase the professional skills of fire protection and fire-fighting personnel and rescue personnel;

(4) To encourage public support for fire prevention and control and rescue services;

(5) To accept gifts, bequests, devises, grants, matching funds, and other considerations from private or governmental sources for use in promoting its work;

(6) To make grants for use in pursuing its objectives, under such conditions as are deemed to be necessary and such other powers as may be necessary to carry out the State's duties with respect to all grants to the State by the United States Fire Administration and the National Fire Academy; and all support programs brought into the State by these two entities shall be coordinated and controlled by the Commission;

(7) To make studies and recommendations for the improvement of fire prevention and control and rescue services in the State and to make studies and recommendations for the coordination and implementation of effective fire prevention and control and rescue services and for effective fire prevention and control and rescue services education;

(8) To set objectives and priorities for the improvement of fire prevention and control and rescue services throughout the State;

(9) To advise State and local interests of opportunities for securing federal assistance for fire prevention and control and rescue services and for improving fire prevention and control and rescue services administration and planning within the State of North Carolina;

(10) To assist State agencies and institutions of local government and combinations thereof in the preparation and processing of applications for financial aid and to support fire prevention and control, rescue services, and planning and administration;

(11) To encourage and assist coordination at the federal, State and local government levels in the preparation and implementation of fire prevention and control and rescue services administrative improvements and crime reduction plans;

(12) To apply for, receive, disburse and audit the use of funds received from any public and private agencies and instrumentalities for fire prevention and control and rescue services, their administration and plans therefor;

(13) To enter into monitoring and evaluating the results of contracts and agreements necessary or incidental to the discharge of its assigned responsibilities;

(14) To provide technical assistance to State and local fire prevention and control and rescue agencies in developing programs for improvement;

(14a) To serve as a central office for the collection and dissemination of information relative to fire service and rescue service activities and programs in State government. All State government agencies conducting fire service and rescue service related programs and activities shall report the status of these programs and activities to the Commission on a quarterly basis and they shall also report to the Commission any new programs or changes to existing programs as they are implemented;

(14b) To establish voluntary minimum professional qualifications for all levels of fire service and rescue service personnel;

(14c) To prepare an annual report to the Governor on its fire prevention and control activities and plans, rescue activities and plans, and to recommend legislation concerning fire prevention and control and rescue services;

(14d) To reimburse the members of the Commission's certification board, in accordance with G.S. 138-5, for travel and subsistence expenses incurred by them in their duties as certification board officers; and

(15) To take such other actions as may be deemed necessary or appropriate to carry out its assigned duties and responsibilities.

(16) To provide workers' compensation benefits under G.S. 58-87-10, to create a Volunteer Safety Workers' Compensation Board to assist it in performing this duty, and to reimburse the members of the Commission's Volunteer Safety Workers' Compensation Board in accordance with G.S. 138-5 for travel and subsistence expenses incurred by them.

(b) Each State agency involved in fire prevention and control or rescue related activities shall furnish the executive director of the

Commission such information as may be required to carry out the intent of this section. (1977, c. 1064, s. 1; 1981, c. 791, ss. 3, 4; 1985, c. 757, s. 167(b); 1989, c. 750, s. 1; 1993, c. 321, s. 41; 1995, c. 507, s. 7.21A(c).)

Editor's Note. — Session Laws 1995, c. 507, s. 1.1, provides that this act shall be known and cited as the Expansion and Capital Improvements Appropriations Act of 1995. Session Laws 1995, c. 507, s. 28.12 is a severability cause.

ARTICLE 81.

Hotels; Safety Provisions.

§ 58-81-1: Repealed by Session Laws 1995, c. 517, s. 33, effective July 29, 1995.

Editor's Note. — Session Laws 1995, c. 517, s. 41 contains a severability clause.

ARTICLE 83.

Mutual Aid between Fire Departments.

§ 58-83-1. Authority to send firemen and apparatus beyond territorial limits; privileges and immunities.

CASE NOTES

Cited in Hix v. Jenkins, 118 N.C. App. 103, 453 S.E.2d 551 (1995).

ARTICLE 84.

Fund Derived from Insurance Companies.

§ 58-84-1. Fire and lightning insurance report.

Every insurance company doing business in a fire district in this State shall report to the Secretary of Revenue by March 15 of each year a just and true account of all premiums collected and received from all fire and lightning insurance business done within the limits of each fire district during the preceding calendar year and shall pay the tax levied in G.S. 105-228.5(d)(4). The Secretary of Revenue shall provide the Commissioner the reports filed pursuant to this section and shall credit the net proceeds of the tax to the Department of Insurance for disbursement pursuant to G.S. 58-84-25. (1907, c. 831, s. 1; 1919, c. 180; C.S., s. 6063; 1929, c. 286; 1989, c. 485, s. 63; 1995 (Reg. Sess., 1996), c. 747, s. 4.)

Local Supplemental Firemen's Retirement Fund. — City of Lumberton: 1995 (Reg. Sess., 1996), c. 699; city of Mount Airy: 1995, c. 165, s. 1; city of Wilson: 1995 (Reg. Sess., 1996), c. 678.

Local Modification. —

For additional local modifications to the Local Supplemental Firemen's Retirement Fund, see the main pamphlet.

By virtue of Session Laws 1997-52, city of Albemarle: 1957, c. 102, s. 9, should be stricken from the main volume. By virtue of Session Laws 1997-460, city of Raleigh: 1969, c. 421; 1975, c. 504; 1979, c. 328; 1989 (Reg. Sess., 1990), c. 917 should be stricken from the main volume.

Editor's Note. —

Session Laws 1995, c. 34, s. 4, effective April 13, 1995, repealed SessionLaws 1969, cc. 481 and 1072, concerning the Local Supplemental Firemen's Retirement Fund for the city of Roanoke Rapids.

Session Laws 1995 (Reg. Sess., 1996), c. 747, s. 16, provides: "This act does not obligate the General Assembly to appropriate funds."

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective January 1, 1997, rewrote this section.

§ 58-84-5. Definitions.

The following definitions apply in Articles 84 through 88 of this Chapter:

(1) City. — A fire district.

(2) Clerk. — The clerk of a fire district or, if there is no clerk, the person so designated by the governing body of the fire district.

(3) Fire district. — Any political subdivision of the State that meets all of the following conditions:

   a. It has an organized fire department under the control of its governing body.

   b. Its fire department has apparatus and equipment that is in serviceable condition for fire duty and is valued at one thousand dollars ($1,000) or more.

   c. It enforces the fire laws to the satisfaction of the Commissioner.

(4) Town. — A fire district. (1951, c. 1032, s. 1; 1995 (Reg. Sess., 1996), c. 747, s. 5.)

Editor's Note. — Session Laws 1995 (Reg. Sess., 1996), c. 747, s. 16, provides: "This act does not obligate the General Assembly to appropriate funds."

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective January 1, 1997, rewrote this section.

§§ 58-84-10 through 58-84-20: Repealed by Session Laws 1995 (Regular Session, 1996), c. 747, s. 6, effective January 1, 1996.

Editor's Note. — Session Laws 1995 (Reg. Sess., 1996), c. 747, s. 16, provides: "This act does not obligate the General Assembly to appropriate funds."

§ 58-84-25. Disbursement of funds by Insurance Commissioner.

The Insurance Commissioner shall deduct the sum of three percent (3%) from the tax proceeds credited to the Department pursuant to G.S. 105-228.5(d)(4) and pay the same over to the treasurer of the State Firemen's Association for general purposes.

The Insurance Commissioner shall deduct the sum of two percent (2%) from the tax proceeds and retain the same in the budget of the Department of Insurance for the purpose of administering the disbursement of funds by the board of trustees in accordance with the provisions of G.S. 58-84-35. The Insurance Commissioner shall, pursuant to G.S. 58-84-50, credit the amount forfeited by nonmember fire districts to the North Carolina State Firemen's Association. The Insurance Commissioner shall pay the remaining tax proceeds to the treasurer of each fire district in proportion to the amount of business done in the fire district. These funds shall be held by the treasurer as a separate and distinct fund. The fire district shall immediately pay the funds to the treasurer of the local board of trustees upon the treasurer's election and qualification, for the use of the board of trustees of the firemen's local relief fund in each fire district, which board shall be composed of five members, residents of the fire district as hereinafter provided for, to be used by it for the purposes provided in G.S. 58-84-35. (1907, c. 831, s. 5; C.S., s. 6067; 1925, c. 41; 1985 (Reg. Sess., 1986), c. 1014, s. 168; 1989, c. 485, s. 63; 1995 (Reg. Sess., 1996), c. 747, s. 7.)

Editor's Note. — Session Laws 1995 (Reg. Sess., 1996), c. 747, s. 16, provides: "This act does not obligate the General Assembly to appropriate funds."

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective January 1, 1997, rewrote this section.

§ 58-84-30. Trustees appointed; organization.

Local Supplemental Firemen's Retirement Fund. — City of Lumberton: 1995 (Reg. Sess., 1996), c. 699.

Local Modification. — For additional local modifications see the main pamphlet.

§ 58-84-35. Disbursement of funds by trustees.

The board of trustees shall have entire control of the funds derived from the provisions of this Article, and shall disburse the funds only for the following purposes:

(1) To safeguard any fireman in active service from financial loss, occasioned by sickness contracted or injury received while in the performance of his duties as a fireman.

(2) To provide a reasonable support for those actually dependent upon the services of any fireman who may lose his life in the fire service of his town, city, or State, either by accident or from disease contracted or injury received by reason of such service. The amount is to be determined according to the earning capacity of the deceased.

(2a) To provide assistance, upon approval by the Secretary of the State Firemen's Association, to a destitute member fireman who has served honorably for at least five years.

(3) Repealed by Session Laws 1985, c. 666, s. 61.

(4) To provide for the payment of any fireman's assessment in the Firemen's Fraternal Insurance Fund of the State of North Carolina if the board of trustees finds as a fact that said fireman is unable to pay the said assessment by reason of disability.

(5) To provide for benefits of supplemental retirement, workers compensation, and other insurance and pension protection

for firemen otherwise qualifying for benefits from the Firemen's Relief Fund as set forth in Article 85 of this Chapter.

(6) To provide for educational benefits to firemen and their dependents who otherwise qualify for benefits from the Firemen's Relief Fund as set forth in Article 85 of this Chapter.

Notwithstanding any other provisions of law, no expenditures shall be made pursuant to subsections (5) and (6) of this section unless the State Firemen's Association has certified that such expenditures will not render the Fund actuarially unsound for the purposes of providing the benefits set forth in subsections (1), (2), and (4) of this section. If, for any reason, funds made available for subsections (5) and (6) of this section shall be insufficient to pay in full any benefits, the benefits pursuant to subsections (5) and (6) shall be reduced pro rata for as long as the amount of insufficient funds exists. No claim shall accrue with respect to any amount by which a benefit under subsections (5) and (6) shall have been reduced. (1907, c. 831, s. 6; 1919, c. 180; C.S., s. 6069; Ex. Sess. 1921, c. 55; 1923, c. 22; 1925, c. 41; 1945, c. 74, s. 2; 1985, c. 666, s. 61; 1987, c. 174, ss. 2, 3; 1997-456, s. 27.)

Editor's Note. — Subdivision (2.1) of this section was renumbered as subdivision (2a) pursuant to S.L. 1997-456, s. 27, which authorized the Revisor of Statutes to renumber or reletter section and parts of sections having a number or letter designation that is incompatible with the General Assembly's computer database.

Local Modification. — By virtue of Session Laws 1995, c. 302, s. 1, town of Kernersville: 1979, 2nd Sess., c. 1106 should be stricken from the main volume.

For additional local modifications to this section, see the main pamphlet.

ARTICLE 85A.

State Fire Protection Grant Fund.

§ 58-85A-1. Creation of Fund; allocation to local fire districts and political subdivisions of the State.

(a) There is created in the Office of State Budget and Management the State Fire Protection Grant Fund. The purpose of the Fund is to compensate local fire districts and political subdivisions of the State for providing local fire protection to State-owned buildings and their contents.

(b) The Office of State Budget and Management shall develop and implement an equitable and uniform statewide method for distributing any funds to the State's local fire districts and political subdivisions.

Upon the request of the Director of the Budget, the Department of Insurance shall provide the Office of State Budget and Management all information necessary to develop and implement the formula.

(c) It is the intent of the General Assembly to appropriate annually to the State Fire Protection Grant Fund at least three million eighty thousand dollars ($3,080,000) from the General Fund, one hundred fifty thousand dollars ($150,000) from the Highway

Fund, and nine hundred seventy thousand dollars ($970,000) from University of North Carolina receipts. Funds received from the General Fund shall be allocated only for providing local fire protection for State-owned property supported by the General Fund; funds received from the Highway Fund shall be allocated only for providing local fire protection for State-owned property supported by the Highway Fund; and funds received from University of North Carolina receipts shall be allocated only for providing local fire protection for State-owned property supported by University of North Carolina receipts. (1997-443, s. 23(a).)

Editor's Note. — Session Laws 1997-443, s. 35.5, made this Article effective July 1, 1997.

Session Laws 1997-443, s. 23(c), provides that, of the funds appropriated from the General Fund to the Office of State Budget and Management, the sum of $3,080,000 for the 1997-98 fiscal year and $3,080,000 for the 1998-99 fiscal year shall be used for the State Fire Protection Grant Fund.

Session Laws 1997-443, s. 23(d), provides that of the funds appropriated from the Highway Fund to the Office of State Budget and Management, the sum of $150,000 for the 1997-98 fiscal year and $150,000 for the 1998-99 fiscal year shall be used for the State Fire Protection Grant Fund.

Session Laws 1997-443, s. 23(e), provides that of the receipts available to The University of North Carolina, the sum of $970,000 for the 1997-98 fiscal year and $970,000 for the 1998-99 fiscal year shall be transferred to the State Fire Protection Grant Fund for use as provided in subsection (c) of this section.

Session Laws 1997-443, s. 1.1, provides: "This act shall be known as 'The Current Operations and Capital Improvements Appropriations Act of 1997'".

Session Laws 1997-443, s. 35.2, provides: "Except for statutory changes or other provisions that clearly indicate an intention to have effects beyond the 1997-99 fiscal biennium, the textual provisions of this act apply only to funds appropriated for, and activities occurring during, the 1997-99 fiscal biennium."

Session Laws 1997-443, s. 35.4, is a severability clause.

ARTICLE 86.

North Carolina Firemen's and Rescue Squad Workers' Pension Fund.

§ 58-86-30. "Eligible rescue squad worker" defined; determination and certification of eligibility.

"Eligible rescue squad worker" means a person who is a member of a rescue or emergency medical services squad that is eligible for membership in the North Carolina Association of Rescue and Emergency Medical Services, Inc., and who has attended a minimum of 36 hours of training and meetings in the last calendar year. Each rescue or emergency medical services squad eligible for membership in the North Carolina Association of Rescue and Emergency Medical Services, Inc., must file a roster certified by the secretary of the association of those rescue or emergency medical services squad workers meeting the requirements of this section with the State Treasurer by January 1 of each calendar year.

"Eligible rescue squad worker" does not mean "eligible fireman" as defined by G.S. 58-86-25, nor may an "eligible rescue squad worker" qualify also as an "eligible fireman" in order to receive double benefits available under this Article. (1981, c. 1029, s. 1; 1991 (Reg. Sess., 1992), c. 833, s. 3; 1995, c. 507, s. 7.21A(h).)

Editor's Note. — Session Laws 1995, c. 507, s. 1.1, provides that this act shall be known and cited as the Expansion and Capital Improvements Appropriations Act of 1995.

Session Laws 1995, c. 507, s. 28.12 is a severability clause.

§ 58-86-35. Firemen's application for membership in fund; monthly payments by members; payments credited to separate accounts of members.

Those firemen who are eligible pursuant to G.S. 58-86-25 may make application for membership to the board. Each fireman upon becoming a member of the fund shall pay the director of the fund the sum of ten dollars ($10.00) per month. The monthly payments shall be credited to the separate account of the member and shall be kept by the custodian so it is available for payment on withdrawal from membership or retirement. (1957, c. 1420, s. 1; 1959, c. 1212, s. 1; 1981, c. 1029, s. 1; 1995, c. 507, s. 7.21A(d).)

Editor's Note. — Session Laws 1995, c. 507, s. 1.1, provides that this act shall be known and cited as the Expansion and Capital Improvements Appropriations Act of 1995.

Session Laws 1995, c. 507, s. 28.12 is a severability clause.

§ 58-86-40. Rescue squad worker's application for membership in funds; monthly payments by members; payments credited to separate accounts of members.

Those rescue squad workers eligible pursuant to G.S. 58-86-30 may apply to the board for membership. Each eligible rescue squad worker upon becoming a member shall pay the director of the fund the sum of ten dollars ($10.00) per month. The monthly payments shall be credited to the separate account of the member and shall be kept by the custodian so it is available for payment on withdrawal from membership or retirement. (1981, c. 1029, s. 1; 1983, c. 500, s. 1; 1991 (Reg. Sess., 1992), c. 833, s. 4; 1995, c. 507, s. 7.21A(e).)

Editor's Note. — Session Laws 1995, c. 507, s. 1.1, provides that this act shall be known and cited as the Expansion and Capital Improvements Appropriations Act of 1995.

Session Laws 1995, c. 507, s. 28.12 is a severability clause.

§ 58-86-45. Additional retroactive membership.

(a) Any fireman or rescue squad worker who is now eligible and is a member of a fire department or rescue squad chartered by the State of North Carolina and who has not previously elected to become a member may make application through the board of trustees for membership in the fund on or before March 31, 1987. The person shall make a lump sum payment of five dollars ($5.00) per month retroactively to the time he first became eligible to become a member, plus interest at an annual rate of eight percent

(8%), for each year of his retroactive payments. Upon making the lump sum payment, the person shall be given credit for all prior service in the same manner as if he had made application for membership at the time he first became eligible. Any member who made application for membership subsequent to the time he was first eligible and did not receive credit for prior service may receive credit for this prior service upon lump sum payment of five dollars ($5.00) per month retroactively to the time he first became eligible, plus interest at an annual rate of eight percent (8%), for each year of his retroactive payments. Upon making this lump sum payment, the date of membership shall be the same as if he had made application for membership at the time he was first eligible. Any fireman or rescue squad worker who has applied for prior service under this subsection shall have until October 1, 1989, to pay for this prior service and, if this payment is not made by October 1, 1989, he shall not receive credit for this service, except as provided in subsection (a1) of this section.

(a1) Effective July 1, 1993, any fireman or rescue squad worker who is a current or former member of a fire department or rescue squad chartered by the State of North Carolina may purchase credit for any periods of service to any chartered fire department or rescue squad not otherwise creditable by making a lump sum payment to the Annuity Savings Fund equal to the full liability of the service credits calculated on the basis of the assumptions used for purposes of the actuarial valuation of the system's liabilities, which payment shall take into account the retirement allowance arising on account of the additional service credit commencing at the earliest age at which the member could retire on a retirement allowance, as determined by the board of trustees upon the advice of the consulting actuary, plus an administrative fee to be set by the board of trustees.

(b) An eligible fireman or rescue squad worker who is not yet 35 years old and has not previously elected to become a member may apply to the board of trustees for membership in the fund at any time. Upon becoming a member, the worker must make a lump sum payment of ten dollars ($10.00) per month retroactively to the time the worker first became eligible to become a member, plus interest at an annual rate to be set by the board for each year of retroactive payments. Upon making this lump sum payment, the worker shall be given credit for all prior service in the same manner as if the worker had applied for membership upon first becoming eligible.

A member who is not yet 35 years old, who applied for membership after first becoming eligible, and who did not receive credit for prior service may receive credit for the prior service upon making a lump sum payment of ten dollars ($10.00) for each month since the worker first became eligible, plus interest at an annual rate to be set by the board for each year of retroactive payments. Upon making this lump sum payment, the date of membership shall be the same as if the worker had applied for membership upon first becoming eligible. (1985 (Reg. Sess., 1986), c. 1014, s. 49.1(a); 1989, c. 693; 1993, c. 429, s. 1; 1995, c. 507, s. 7.21A(f).)

Editor's Note. — Session Laws 1995, c. 507, s. 1.1, provides that this act shall be known and cited as the Expansion and Capital Improvements Appropriations Act of 1995.

Session Laws 1995, c. 507, which amended this section, in s. 7.21A(i) provides: "The changes made to G.S. 58-86-45 and G.S. 58-86-55 by this Part do not affect the credit received for service performed before July 1, 1995. The increase in monthly pension contributions from five dollars ($5.00) to ten dollars ($10.00) in G.S. 58-86-55 does not affect the amount of monthly contributions made prior to July 1, 1995."

Session Laws 1995, c. 507, s. 28.9, provides: "Except for statutory changes or other provisions that clearly indicate an intention to have effects beyond the 1995-97 fiscal biennium, the textual provisions of this act apply only to funds appropriated for, and activities occurring during, the 1995-97 biennium."

Session Laws 1995, c. 507, s. 28.12 is a severability clause.

§ 58-86-55. Monthly pensions upon retirement.

Any member who has served 20 years as an "eligible fireman" or "eligible rescue squad worker" in the State of North Carolina, as provided in G.S. 58-86-25 and G.S. 58-86-30, and who has attained the age of 55 years is entitled to be paid a monthly pension from this fund. The monthly pension shall be in the amount of one hundred forty-one dollars ($141.00) per month. Any retired fireman receiving a pension shall, effective July 1, 1997, receive a pension of one hundred forty-one dollars ($141.00) per month.

Members shall pay ten dollars ($10.00) per month as required by G.S. 58-86-35 and G.S. 58-86-40 for a period of no longer than 20 years. No "eligible rescue squad member" shall receive a pension prior to July 1, 1983. No member shall be entitled to a pension hereunder until the member's official duties as a fireman or rescue squad worker for which the member is paid compensation shall have been terminated and the member shall have retired as such according to standards or rules fixed by the board of trustees.

A member who is totally and permanently disabled while in the discharge of the member's official duties as a result of bodily injuries sustained or as a result of extreme exercise or extreme activity experienced in the course and scope of those official duties and who leaves the fire or rescue squad service because of this disability shall be entitled to be paid from the fund a monthly benefit in an amount of one hundred forty-one dollars ($141.00) per month beginning the first month after the member's fifty-fifth birthday. All applications for disability are subject to the approval of the board who may appoint physicians to examine and evaluate the disabled member prior to approval of the application, and annually thereafter. Any disabled member shall not be required to make the monthly payment of ten dollars ($10.00) as required by G.S. 58-86-35 and G.S. 58-86-40.

A member who is totally and permanently disabled for any cause, other than line of duty, who leaves the fire or rescue squad service because of this disability and who has at least 10 years of service with the pension fund, may be permitted to continue making a monthly contribution of ten dollars ($10.00) to the fund until the member has made contributions for a total of 240 months. The member shall upon attaining the age of 55 years be entitled to receive a pension as provided by this section. All applications for disability are subject to the approval of the board who may appoint physicians to examine and evaluate the disabled member prior to approval of the application and annually thereafter.

A member who, because his residence is annexed by a city under Part 2 or Part 3 of Article 4 of Chapter 160A of the General Statutes, or whose department is closed because of an annexation by a city under Part 2 or Part 3 of Article 4 of Chapter 160A of the General Statutes, and because of such annexation is unable to perform as a fireman of any status, and if the member has at least 10 years of service with the pension fund, may be permitted to continue making a monthly contribution of ten dollars ($10.00) to the fund until the member has made contributions for a total of 240 months. The member upon attaining the age of 55 years and completion of such contributions shall be entitled to receive a pension as provided by this section. Any application to make monthly contributions under this section shall be subject to a finding of eligibility by the Board of Trustees upon application of the member.

The pensions provided shall be in addition to all other pensions or benefits under any other statutes of the State of North Carolina or the United States, notwithstanding any exclusionary provisions of other pensions or retirement systems provided by law. (1957, c. 1420, s. 1; 1959, c. 1212, s. 1; 1961, c. 980; 1971, c. 336; 1977, c. 926, s. 1; 1981, c. 1029, s. 1; 1983, c. 500, s. 2; c. 636, s. 24; 1985 (Reg. Sess., 1986), c. 1014, s. 49.1(b); 1987 (Reg. Sess., 1988), c. 1099, s. 1; 1991, c. 720, s. 48; 1993 (Reg. Sess., 1994), c. 653, s. 1; 1995, c. 507, s. 7.21A(g); 1997-443, s. 33.25(a).)

Editor's Note. —

Session Laws 1995, c. 507, s. 1.1, provides that this act shall be known and cited as the Expansion and Capital Improvements Appropriations Act of 1995.

Session Laws 1995, c. 507, which amended this section, in s. 7.21A(i) provides: "The changes made to G.S. 58-86-45 and G.S. 58-86-55 by this Part do not affect the credit received for service performed before July 1, 1995. The increase in monthly pension contributions from five dollars ($5.00) to ten dollars ($10.00) in G.S. 58-86-55 does not affect the amount of monthly contributions made prior to July 1, 1995."

Session Laws 1995, c. 507, s. 28.9, provides: "Except for statutory changes or other provisions that clearly indicate an intention to have effects beyond the 1995-97 fiscal biennium, the textual provisions of this act apply only to funds appropriated for, and activities occurring during, the 1995-97 biennium."

Session Laws 1995, c. 507, s. 28.12 is a severability clause.

Session Laws 1997-443, s. 33.25(b), provides: "It is the intent of the General Assembly to provide cost-of-living increases to members and retirees of the Firemen's and Rescue Squad Workers' Pension Fund at a rate equal to any cost-of-living increases provided to beneficiaries of the Teachers' and State Employees' Retirement System, to the extent that funds are available."

Session Laws 1997-443, s. 1.1, provides: "This act shall be known as 'The Current Operations and Capital Improvements Appropriations Act of 1997'".

Session Laws 1997-443, s. 35.2, provides: "Except for statutory changes or other provisions that clearly indicate an intention to have effects beyond the 1997-99 fiscal biennium, the textual provisions of this act apply only to funds appropriated for, and activities occurring during, the 1997-99 fiscal biennium."

Session Laws 1997-443, s. 35.4, is a severability clause.

Effect of Amendments. — The 1997 amendment, effective July 1, 1997, substituted "one hundred forty-one dollars ($141.00)" for "one hundred thirty-five dollars ($135.00)" twice in the first paragraph and in the third paragraph, and substituted "shall, effective July 1, 1997" for "of one hundred ten dollars ($110.00) per month shall, effective July 1, 1995" in the first paragraph.

Article 87.

Volunteer Safety Workers Assistance.

§ 58-87-1. Volunteer Fire Department Fund.

(a) There is created the Volunteer Fire Department Fund to provide matching grants to volunteer fire departments to purchase equipment and make capital improvements. The Fund shall be set up in the Department of Insurance. The State Treasurer shall invest its assets according to law, and the earnings shall remain in the Fund. The Fund shall be distributed under the direction of the Commissioner of Insurance. Beginning January 1, 1988, an eligible fire department may apply to the Commissioner of Insurance for a grant under this section. Beginning May 1, 1988, and on each May 15, thereafter, the Commissioner shall make grants to eligible fire departments subject to the following limitations:

(1) The size of a grant may not exceed twenty thousand dollars ($20,000);
(2) The applicant shall match the grant on a dollar-for-dollar basis;
(3) The grant may be used only for equipment purchases or capital expenditures necessary to provide fire protection services; and
(4) An applicant may receive no more than one grant per fiscal year.

In awarding grants under this section, the Commissioner shall to the extent possible select applicants from all parts of the State based upon need. Up to two percent (2%) of the Fund may be used for additional staff and resources to administer the Fund in each fiscal year.

No fire department may be declared ineligible for a grant under this section solely because it is classified as a municipal fire department.

(b) A fire department is eligible for a grant under this section if it meets all of the following conditions:

(1) It serves a response area of 6,000 or less in population.
(2) It has no more than two paid members and otherwise consists of volunteer members.
(3) It has been certified by the Department of Insurance.

In making the population determination under subdivision (1), the Department shall use the most recent annual population estimates certified by the State Planning Officer.

(c) The Commissioner of Insurance shall submit a written report to the General Assembly within 60 days after the grants have been made. This report shall contain the amount of the grant and the name of the recipient. (1987, c. 709, s. 1; 1987 (Reg. Sess., 1988), c. 1062, ss. 6-9; 1989, c. 770, s. 30; 1995, c. 507, s. 7.21A(k).)

Editor's Note. — Session Laws 1995, c. 507, s. 1.1, provides that this act shall be known and cited as the Expansion and Capital Improvements Appropriations Act of 1995.

Session Laws 1995, c. 507, s. 28.12 is a severability clause.

§ 58-87-5. Volunteer Rescue/EMS Fund.

(a) There is created in the Department of Insurance the Volunteer Rescue/EMS Fund to provide grants to volunteer rescue units providing rescue or rescue and emergency medical services to purchase equipment and make capital improvements. An eligible rescue or rescue/EMS unit may apply to the Department of Insurance for a grant under this section. The application form and criteria for grants shall be established by the Department. The Department of Health and Human Services shall provide the Department with an advisory priority listing of EMS equipment eligible for funding. The State Treasurer shall invest the Fund's assets according to law, and the earnings shall remain in the Fund. On December 15 of each year, the Department shall make grants to eligible rescue or rescue/EMS units subject to all of the following limitations:

(1) A grant to an applicant who is required to match the grant with non-State funds may not exceed fifteen thousand dollars ($15,000), and a grant to an applicant who is not required to match the grant with non-State funds may not exceed three thousand dollars ($3,000).

(2) An applicant whose liquid assets, when combined with the liquid assets of any corporate affiliate or subsidiary of the applicant, are more than one thousand dollars ($1,000) shall match the grant on a dollar-for-dollar basis with non-State funds.

(3) The grant may be used only for equipment purchases or capital expenditures.

(4) An applicant may receive no more than one grant per fiscal year.

In awarding grants under this section, the Department shall to the extent possible select applicants from all parts of the State based upon need. Up to two percent (2%) of the Fund may be used for additional staff and resources to administer the Fund in each fiscal year. In addition, notwithstanding G.S. 58-78-20, up to four percent (4%) of the Fund may be used for additional staff and resources for the North Carolina Fire and Rescue Commission.

(b) A rescue or rescue/EMS unit is eligible for a grant under this section if it meets all of the following conditions:

(1) Repealed by Session Laws 1989 (Regular Session, 1990), c. 1066, s. 33(a), effective July 15, 1990.

(2) It has no more than two paid members and otherwise consists of volunteer members.

(3) It has been recognized by the Department as an organization that provides rescue or rescue and emergency medical services.

(4) It satisfies the eligibility criteria established by the Department under subsection (a) of this section.

(c) For the purpose of this section and Article 88 of this Chapter, "rescue" means the removal of individuals facing external, nonmedical, and nonpatient related peril to areas of relative safety. A "rescue unit" or "rescue squad" means a group of individuals who are not necessarily trained in emergency medical services, fire fighting, or law enforcement, but who expose themselves to an external, nonmedical, and nonpatient related peril to effect the removal of individuals facing the same type of peril to areas of relative safety. The unit or squad must comply with existing State statutes and with eligibility criteria established by the North Carolina Association of Rescue and Emergency Medical Services, Inc. (1987 (Reg. Sess., 1988), c. 1062, s. 2; 1989, c. 115; c. 534, s. 2; 1989 (Reg. Sess., 1990), c. 1066, s. 33(a); 1991 (Reg. Sess., 1992), c. 943, s. 2; 1995, c. 507, s. 7.21A(l); 1997-443, s. 11A.20.)

Editor's Note. —

Session Laws 1995, c. 507, s. 1.1, provides that this act shall be known and cited as the Expansion and Capital Improvements Appropriations Act of 1995.

Session Laws 1995, c. 507, s. 28.12 is a severability clause.

Session Laws 1997-443, s. 1.1, provides: "This act shall be known as 'The Current Operations and Capital Improvements Appropriations Act of 1997'".

Session Laws 1997-443, s. 35.4, is a severability clause.

Effect of Amendments. — The 1997 amendment, effective August 28, 1997, substituted "Department of Health and Human Services" for "Office of Emergency Medical Services in the Department of Human Resources" in the fourth sentence of subsection (a).

§ 58-87-10. Workers' Compensation Fund for the benefit of volunteer safety workers.

(a) Definition. — As used in this section, the term "eligible unit" means a volunteer fire department or volunteer rescue/EMS unit that is not part of a unit of local government and is exempt from State income tax under G.S. 105-130.11.

(b) Creation. — The Workers' Compensation Fund is created in the Department of Insurance as an expendable trust fund. Accordingly, interest and other investment income earned by the Fund accrues to it, and revenue in the Fund at the end of a fiscal year remains in the Fund and does not revert.

(c) Use. — Revenue in the Workers' Compensation Fund shall be used to provide workers' compensation benefits to members of eligible units. Chapter 97 of the General Statutes governs the payment of benefits from the Fund. Benefits are payable for compensable injuries or deaths that occur on or after July 1, 1996.

(d) Administration. — The State Fire and Rescue Commission, established under G.S. 58-78-1, shall administer the Workers' Compensation Fund and shall perform this duty by contracting with a third-party administrator. The contracting procedure is not subject to Article 3C of Chapter 143 of the General Statutes. The reasonable and necessary expenses incurred by the Commission in administering the Fund shall be paid out of the Fund by the State Treasurer. The Commission may adopt rules to implement this section.

(e) Revenue Source. — Revenue is credited to the Workers' Compensation Fund from appropriations made to the Department of Insurance for this purpose. In addition, every eligible unit that elects to participate shall pay into the Fund an amount set annually by the State Fire and Rescue Commission to ensure that the Fund will be able to meet its payment obligations under this section. The amount shall be set as a per capita fixed dollar amount for each member of the roster of the eligible unit.

The payment shall be made to the State Fire and Rescue Commission on or before July 1 of each year. The Commission shall remit the payments it receives to the State Treasurer, who shall credit the payments to the Fund. If the Commission does not receive an annual payment from an eligible unit by July 1, then that unit shall not receive workers' compensation coverage from the Fund for the fiscal year that begins that July 1. (1995, c. 507, s. 7.21A(a).)

Editor's Note. — Session Laws 1995, c. 507, s. 1.1, provides that this act shall be known and cited as the Expansion and Capital Improvements Appropriations Act of 1995.

Session Laws 1995, c. 507, which enacted this section, in s. 7.21A(b) provides: "The first per member payment that eligible fire departments and rescue/EMS units must make to the State Fire and Rescue Commission under G.S. 58-87-10 is payable on or before July 1, 1996."

Session Laws 1995, c. 507, s. 28.9, provides: "Except for statutory changes or other provisions that clearly indicate an intention to have effects beyond the 1995-97 fiscal biennium, the textual provisions of this act apply only to funds appropriated for, and activities occurring during, the 1995-97 biennium."

Session Laws 1995, c. 507, s. 28.12 is a severability clause.

ARTICLE 88.

Rescue Squad Workers' Relief Fund.

§ 58-88-5. Rescue Squad Workers' Relief Fund; trustees; disbursement of funds.

(a) The "Rescue Squad Workers' Relief Fund" is created. It consists of the revenue credited to the Fund under G.S. 20-183.7(c) and shall be used for the purposes set forth in this Article.

(b) The Executive Committee of the Association shall be the Board of Trustees of the Fund. The Board shall consist of the Commander, Vice-Commander, Secretary-Treasurer, and two past Commanders of the Association. The Commander shall be the Chairman of the Board. The Commander, Vice-Commander, and Secretary-Treasurer shall appoint the two past Commanders of the Association, who shall serve at the pleasure of the appointing officers.

(c) The Commissioner of Insurance has exclusive control of the Fund and shall disburse revenue in the Fund to the Association only for the following purposes:

(1) To safeguard any rescue or EMS worker in active service from financial loss, occasioned by sickness contracted or injury received while in the performance of his or her duties as a rescue or EMS worker.

(2) To provide a reasonable support for those persons actually dependent upon the services of any rescue or EMS worker who may lose his or her life in the service of his or her town, county, city, or the State, either by accident or from disease contracted or injury received by reason of such service. The amount is to be determined according to the earning capacity of the deceased.

(3) To award scholarships to children of members, deceased members or retired members in good standing, for the purpose of attending a two year or four year college or university, and for the purpose of attending a two year course of study at a community college or an accredited trade or technical school, any of which is located in the State of North Carolina. Continuation of the payment of

educational benefits for children of active members shall be conditioned on the continuance of active membership in the rescue or EMS service by the parent or parents.

(4) To pay death benefits to those persons who were actually dependent upon any member killed in the line of duty.

(4a) To pay additional benefits approved by the Board of Trustees of the Fund to rescue and EMS workers who are eligible pursuant to G.S. 58-88-10 and who are members of the Association.

(5) Notwithstanding any other provision of law, no expenditures shall be made pursuant to subdivisions (1), (2), (3), (4), and (4a) of this subsection unless the Board has certified that the expenditures will not render the Fund actuarially unsound for the purpose of providing the benefits set forth in subdivisions (1), (2), (3), (4), and (4a). If, for any reason, funds made available for subdivisions (1), (2), (3), (4), and (4a) are insufficient to pay in full any benefit, the benefits pursuant to subdivisions (1), (2), (3), (4), and (4a) shall be reduced pro rata for as long as the amount of insufficient funds exists. No claims shall accrue with respect to any amount by which a benefit under subdivisions (1), (2), (3), (4), and (4a) has been reduced. (1987, c. 584, s. 5; 1987 (Reg. Sess., 1988), c. 1062, s. 10; 1989 (Reg. Sess., 1990), c. 1066, s. 33(c); 1995, c. 421, s. 1.)

Chapter 58A.

North Carolina Health Insurance Trust Commission.

Editor's Note. — This Chapter was recodified as Article 68 of Chapter 58 under the authority of Session Laws 1987, c. 752, s. 9 and Session Laws 1987 (Reg. Sess., 1988), c. 975, s. 34.

STATE OF NORTH CAROLINA

DEPARTMENT OF JUSTICE

Raleigh, North Carolina

December 1, 1997

I, Michael F. Easley, Attorney General of North Carolina, do hereby certify that the foregoing 1997 Cumulative Supplement to the General Statutes of North Carolina was prepared and published by Michie under the supervision of the Department of Justice of the State of North Carolina.

MICHAEL F. EASLEY

Attorney General of North Carolina

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